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DR. CROCKER'S CASE OF LUPUS ERYTHEMATOSUS  
LIKE LICHEN PLANUS.



# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

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### LUPUS ERYTHEMATOSUS AS AN IMITATOR OF VARIOUS FORMS OF DERMATITIS.<sup>1</sup>

(With Colored Plate.)

BY

H. RADCLIFFE-CROCKER, M.D.,

London, England.

WE are all pretty well accustomed to the multiformity of aspect with which diseases of the skin present themselves to our notice, and indeed it is their infinite variety of appearance, course and development which produce many of the difficulties, and much of the interest of the subject. Eczema, scabies and the syphilitic eruptions are proverbial for their polymorphism, but lupus erythematosus comes but little if at all behind them, and, as an imitator of various forms of simple dermatitis, it is a formidable rival to syphilis itself. It is to this aspect of the disease that I wish to direct your attention to-day by relating some cases and showing you drawings which illustrate the points I desire to place before you.

As we usually see it, lupus erythematosus is at least a scaly, and often a crusted eruption, but in a small number of cases the skin surface is quite undisturbed, and only presents the appearance of red, thickened, well-defined, smooth patches remarkably like an erythema multiforme, from which it is distinguished by its slow development, its persistence and tendency to spread at the margins, with or without some central involution. Eventually, however, it is very likely to become scaly,

<sup>1</sup> Read at the 17th Annual Meeting of the American Dermatological Association.

and develop into the common form, with horny plugs deeply inserted into the sebaceous orifices.

The first case is an instance of the lupus imitating erythema tuberculatum.

*Case I. Lupus Erythematosus Like Erythema Tuberculatum.*—Mrs. H., æt. 27, was sent to me on May 24, 1892, by Dr. Burgess. The lesions commenced at the age of 10 years on the right cheek. There was only one spot for the first two years; then others formed on the side of the nose, and they then became scattered irregularly over the face, but with the exception of the hemp-seed sized nodule on the left ear there were none anywhere else. The lobes of both ears were atrophied looking, but she said there had never been any lesions on them. All the lesions were exactly like an erythema tuberculatum varying from a hemp-seed to half an inch in diameter, quite smooth, except one on the side of the nose, which was scaly. They were of a uniform purplish red, except one, which was whiter in the center. Her general health was fairly good; she had had four children and three premature deliveries, one at six months, and twins at seven months. One of the children died at three months old of "consumption of the bowels"; her paternal grandmother died of phthisis. Several of the spots disappeared under the application of a paint, salicylic acid 20 grains, collodion 1 oz.

In Case 2 the drawing (drawing shown) shows an advanced condition of the disease, which began in a similar form to Case I.

*Case II. Lupus Erythematosus Like Erythema Tuberculatum.*—Mr. G., æt. 51, came to me on December 1, 1887. On November 5, 1885, he accidentally cut his lip. About Christmas of that year a spot or two appeared and gradually got worse, on the whole; though sometimes it had flattened down and paled none of it had ever gone away except, perhaps, two spots, which the wife thought had disappeared.

The eruption was very symmetrical on both cheeks, on both ears and a little under the lower jaw. It consisted of aggregations of split-pea sized, flattish, well-defined, bright red papules, many of them arranged so as to form circular patches with a depressed center. There were some segregated lesions, rounder and larger, of which those on the ears were well-marked examples. They were firm to the touch, but the whole tissue appeared much thickened. There were no subjective symptoms. The patient was a stout, healthy-looking man, but

had recently been exposed to bad drains. Five months later I saw him again; the eruption had spread considerably, but on the face nearly all the lesions had coalesced into a large area with prominent margins and partially involuted center, but there was no perceptible scarring, and in parts the component nodules were still distinguishable. The color was still a deep red, and as my notes say, just like an erythema exudativum.

In July, 1893, he came to me again at my request, and then the drawing was made. There was considerable extension of the disease on the forehead, under the chin and nearly all over the cheeks.

It still, however, preserved its erythematous character except in a patch over the right brow, where it displayed the commoner sebaceous character. His general health was good, but he was much exposed to the weather from having to drive a good deal in all weathers.

The third drawing illustrates both the erythematous and sebaceous characters in a still more marked degree than the first.

*Case III. Lupus Erythematosus Like Erythema Papulatum.*—William H., æt. 42, cab driver, came to University College Hospital on July 15, 1893.

Two years previously he had some rash on the cheeks which lasted a month only, and it was not until about a year ago that the present eruption began on the sides of the cheek, and has gradually extended until it reached its present condition. The eruption when seen occupied the whole of the face below the eyebrows, the orbits themselves and the lower lip escaping, but the chin, except in the center, was affected. On the left side it extended above the brow, but below the orbits it was remarkably symmetrical. The most recent lesions were on the lower part of the sides of the face, and below the jaw. In these positions they were in the form of erythematous, slightly raised discs from half to a quarter of an inch in diameter, the most recent were quite smooth and slightly convex, the larger ones were not prominent in the centre and but slightly scaly there. In the upper parts of the cheeks and nose they had coalesced into an almost continuous patch. On the nose the surface was slightly sunk below the erythematous border, and there was the yellowish rough surface with horny sebaceous plugs, such as is usual in the commoner forms of lupus erythematosus. The same condition in a lower degree was present over the malar eminences, but in the rest of the cheeks the follicular orifices were only

slightly more marked than usual. The lobes of the ears were cicatricial ; on the scalp were numerous bald patches mostly on and about the vertex.

In some, the follicles were plugged, as in the face, but not all over the patch. In others there was no perceptible change except that the hair was gone. On the right leg was the scar of a large circular ulcer the cause of which was doubtful. He denied having had syphilis and there was no evidence of it besides the ulcer, but he admitted having had gonorrhœa more than twenty years previously. His father died of phthisis, but except some deafness he himself had good health.

The diffuse form of erythema is more common than the papular or nodular form, and is illustrated both in the drawing and also in plate 42 of the Sydenham Society's Atlas ; it is to this form that the disease owes its name. A variety of it, the chilblain lupus of Hutchinson, is also well illustrated in this plate.

The history of the patient from whom the drawing was taken is as follows :

*Case IV. Lupus Erythematosus (Diffuse Erythema).—*Margaret B., æt. 43, came as an out-patient to University College Hospital June 27, 1891.

The disease had commenced three years previously as a small red spot on the side of the nose, and had spread continuously. The whole nose was intensely reddened and slightly scaly and the skin was thickened and infiltrated, but the orifices of the sebaceous glands were not patent or plugged. There was no history of phthisis in the family nor was she subject to chilblains, but she had had much domestic trouble. Her circumstances were fairly good. This patient improved much under treatment, the cheek patches quite disappeared, without any scarring, the nose also was much much improved and became quite pale.

Another disease which lupus erythematosus imitates is psoriasis, of which the following case is an instance.

*Case VI. Lupus Erythematosus Like Psoriasis Guttata on the Breast.*—Annie C., æt. 36, was sent to me by Mr. Gilbert Smith, of Birmingham, on May 28, 1892.

She stated that four years previously she had noticed a spot on the nose near the right, inner canthus of the eye ; this was burnt three times and then spread all over the nose. When first seen by me the disease occupied the whole nose except the root, was well defined at the margins, with thin adherent scales all over, except at the tip, which was smooth from Mr. Gilbert Smith's treatment. Soon after



the nose was affected, a large number of spots appeared on the breast, not quite so many as now, but none have gone away and some fresh ones have since appeared. These consisted of bright, red, flat patches, rather well defined, very slightly scaly when I saw her, but became more so if ointment was not applied. Sometimes they itched slightly, but as a rule, she did not feel anything either on the breast or the nose.

Both breasts were symmetrically affected, but there was rather more eruption on the right than the left; the nipple was quite free and the areola was only slightly affected. The lesions were limited almost entirely to the upper surface; there were a very few below near the areola.

On the back, beneath the scapula, there was another eruption, the distribution was bounded above by a horizontal line at the level of the angle of the scapula, and below by the rib margin, the great bulk of the lesions ceased at the posterior axillary fold, but a few extended to the front. The eruption was composed of thickly crowded, slightly raised, flattish elevations of pretty uniform size. The great bulk of them were about an eighth of an inch in diameter, a few were smaller, they were pale red, and very slightly scaly. These lesions came out in Spring and Autumn, lasted a month or six weeks and then disappeared.

Somewhat similar lesions affected the limbs, but while the arms were now nearly free, they were sparsely scattered over the front of the legs though not so prominently as on the back. They were very abundant along the borders of the feet, especially on the outer side, the middle of the sole and on the toes. On the big and third toe they formed a patch purplish red, sharply defined, with slightly scaly points here and there. Those on the legs disappeared with the rest, but those on the feet were more persistent.

I need scarcely remind you that this is not the same as Hutchinson's lupus psoriasis, which is only a form of lupus vulgaris, in which the lesions are very numerous, superficial and scaly. It is illustrated in plate 19 of the Sydenham Society, and I have a drawing of a similar case.

A rarer imitation is that of lichen planus, of which I have seen only two instances—one of these

*Case VII. Lupus Erythematosus Resembling Lichen Planus.* (See colored plate.)—Alexander J. T., aet. 20, photographer, came first to University College Hospital on May 25, 1892. The disease for which he sought advice began when he was in

good health, four years previously, on the right wrist, and on the extensor aspect of the root of the thumb. The first lesions were two slit-pea sized slightly raised flat nodules of a pale red color, which were accompanied by slight itching. They increased very slightly in size and number, fresh papules appearing on the back of the right wrist and on the right and left forefingers and on the back of left hand. Those on the head, he thinks, came about the same time. Those on the back of the wrist coalesced into patches. During the last two years fresh patches have appeared on the left middle finger, on the first and terminal phalanges, and over the fifth left metacarpal bone. There were lesions also present on the nape over both mastoid processes, on the right ear, the right inner canthus, and just below the right lower jaw.

They formed patches evidently made up of aggregations of papules of a violaceous red tint, exactly like that of lichen planus, but very finely scaly; the patches had undergone involution in the center, the smaller patches thus formed circles of coalescent papules with a depressed center; the larger patches had apparently gone a step farther and formed irregular gyrate patches, with part of their border completely involuted. All the patches had a narrow bright red areola and spread at the border; the nape lesions were still discrete, of a bright red, and formed two irregular groups of four papules each, with a single papule below them. The head lesions were, for the most part, round the scalp at the hairy border. Behind the left ear there was only the trace of a patch of a yellowish tint, to be more clearly felt than seen, the center having involuted. Behind the right ear the patch was larger, but faint and of a yellowish hue. There was another yellowish patch just within the border of the hair on the left side, and another over the right temple. At the right inner canthus the nodule was only just perceptible, almost the color of the normal skin. There was a colorless nodule in the center of the ear in the front of the helix. These yellowish patches were very suggestive of lupus erythematosus.

The patient was a thin but fairly well-developed man, not strong, subject to a cough in the Winter, but he presented no signs of phthisis. His father and mother were alive and well. His five sisters and one brother have all weak chests, but none of them have died of phthisis, and he is not aware of its being in the family.

He was taken into the hospital, and some of the patches on

the right wrist excised, and also the isolated nodules at the nape. The wrist specimens were lost, but the nape lesions were examined microscopically, and showed the characters of lupus erythematosus.

The second case was sent to me by my friend, Dr. Colcott Fox for an opinion, and I am bound to say that he regards it as really lichen planus. I will only show the model and drawing; as probably he will publish the case himself.

I now reach more debatable ground, as the diagnosis of lupus erythematosus is open to dispute.

The first group comprises cases which resemble lupus vulgaris very remarkably, and indeed indistinguishably, as far as appearance is concerned, but resemble lupus erythematosus in the age of the patients, the number, and the distribution of the lesions, and the course of the eruption as a whole.

The most remarkable case is that of which this drawing, taken in July last, represents a late stage, and that after much treatment.

*Case IX. Lupus Erythematosus Nodulatum.*—Lady P. came to me first on February 21, 1888. She stated that the eruption first appeared eighteen months previously on the upper lip as two little brownish red pimples, when she was traveling on the Danube in very hot weather. The others had gradually developed since.

When seen the lesions were symmetrically distributed on each side of the forehead, on the borders of the hair, along each side of the nose, on the upper lip and on each auricle. On the forehead they formed two small groups, one with five and the other with only two papules. The individual nodules were from a hemp-seed to a pea in size, brownish red in color, semi-translucent, and soft to the touch. The larger ones showed signs of involution, with depression in the center. On the nose, lip and ear they were distinct nodules of the same brownish red color. They were attended with no pain or irritation. She had been treated for syphilis and had been salivated, but without producing any alteration in the lesions. She suffered from time to time with paroxysms of pain in the hepatic region, but never had had jaundice, and the attacks were largely due to flatulence. She had no organic disease of any kind. Attempts were made to destroy the growths with the strong acid nitrate of mercury, and subsequently they were scraped with a curette. Improvement resulted, but the drawing, taken in July, 1893, shows that the result was imperfect, though probably from im-

provement in her general health the disease was no longer active. It should have been noted that there were two or three small nodules on the back of the right hand.

I have met with three or four other cases of this kind, but not with so many foci of disease. In two cases there was only a single nodule in each. I also remember a case in which there were even more foci of disease in a patient of the late Dr. Tilbury Fox. Cavafy also showed a case at the Dermatological Society of London in 1892, but I am not aware of any other cases having been recorded.

The Telangiectic form is not usually described in text-books and appears like simply dilated vessels so common in the cheeks, but the patch is sharply defined, and there is great thickening of the subjacent tissues. The following is a good example:

*Case X. Lupus Erythematosus (Telangiectic).*—Mr. C. H. M., æt. 41, was first seen by me on April 17, 1893. He dated his disease to between seven and eight years previously, when he was in Egypt, where he lived for four months, but on cross-examination admitted that he had redness over the malar eminence on the right side only for a much longer time; indeed, the only points on which he was positive were, that he had nothing at all in 1879 and that the left cheek had only been affected between four or five years. His family, personal history and health were good; no signs of phthisis in himself or family.

When seen, both cheeks were symmetrically affected, each with a large telangiectic patch of a purplish red tint, but more extensive on the right side, which was very slightly scaly, but the left was quite smooth. There was considerable thickening when the affected part was pinched up, but the appearance was only that of intense well-defined vascularity. There was a small new spot on the right cheek, to the right of the main patch. This had formed during the present year.

There is another telangiectic or nævoid form of disease, described by Hutchinson under the name "lupus marginatus" and considered by him to be referable to lupus erythematosus, as it is serpiginous, and spreads by "infective satellites." Lassar at the International Congress for 1890 showed a wax case of the same affection which he independently referred to as lupus erythematosus. I therefore mention them here, though I consider that such cases have been referred to lupus erythematosus on very slender evidence, and in my text-book have described them under the title of angioma serpiginosum. It



is a very rare condition, seen chiefly on the limbs, and consists of small florid stippled rings of minute capillary tufts, or dots. Aggregations of these may cover a large area on the limb, the development of which is thus described: "It would appear as if little satellite spots had been produced, which had spread into circles, and by gradually advancing, by infective edges, had coalesced and produced an irregular pattern." They were extremely superficial and in the case referred to "the enlarged capillaries could be partially emptied by pressure, but not wholly, and in many places were distended with deep purple venous blood, which could not be pressed out." He thought that there was slight tendency to scarring. The disease started in the case related from a small port wine stain, observed on the back of the arm soon after birth, and it appears to be the rule that they commence in early childhood, but whether from a *nævus* or not cannot be determined.<sup>1</sup>

These groups of cases imitate, therefore, erythema in a papular, nodular and diffuse form; psoriasis guttata; lichen planus in patches; lupus vulgaris in multiple single nodules or small groups of nodules, persistent telangiectasis of the cutaneous vessels of the malar eminence, and, if the angioma serpiginosum cases are to be included, a special capillary *nævoid* form. While I have no doubt most of the types are quite familiar to you, I hope by drawing attention to them in an assembly like the present to elicit further illustrations of interesting character, and probably also additional types, since the experience of a single observer cannot hope to furnish them all.

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EXTRACTS FROM A JAPANESE WORK ON SYPHILIS.

BY

ALBERT S. ASHMEAD, M.D.,

New York.

I HAVE extracted the following remarks from a Japanese work published in Kioto, 1801, and entitled "Brief Account of Syphilis" (*Bai-o-yaku-gen*). There are two volumes to it. The first contains general remarks, manner of examination, chancre, bubo, secondary syphilis. The second vol-

<sup>1</sup> Hutchinson's Archives of Surg., Vol. 1, No. 3, 1890, plate IX., col. Compare also Plate VI. and VII. and XIV. and XV., in which the face was affected as well as the arm.

A brief history of Lassar's case, p. 112, Vol. 1 of the same, and Dr. Jamieson's case is recorded at p. 71, with histology; his case seemed to be started by a strain at gymnastics.

ume treats of secondary syphilis, tertiary syphilis, and what the author calls miscellaneous syphilis, which means, in all probability, complications. It contains further, sequelæ of syphilis, syphilis of women and children, conditions where medicines are injurious, manner of curing mischievous effect of calomel, treatment by warm springs, diet.

According to the author, syphilis existed, and was included among skin diseases as far back as the Chu dynasty<sup>1</sup>, that is about seven hundred years before Christ. There is a perfect description of chancre, of phagedæna, of bubo. The writer distinguishes between infecting and non-infecting bubo. He declares that there is no separate syphilis for different organs. Wherever it occurs it is always the same disease.

He says that if a child of a syphilitic parent, that is, a congenital syphilitic, becomes inoculated in his turn with syphilis, this is the worst condition of syphilis. Evidently, he believes that a congenital syphilitic can be inoculated with the disease.

The syphilitic poison resides in the fasciæ of muscles and in the marrow of the bones.

He mentions a number of destructive effects of the syphilitic poison; loss of sight, of hearing, falling off of the nose, general emaciation, loss of the penis, ulceration of the anus, putrefaction of the genital organs of women.

These are the remedies to be employed: calomel, mercury, medicated vapors and fumigations, vermilion-lead, the Chinese remedy called *five pearls*, the Japanese *Kyryō*. The idea that moxæ offer a point of escape to the poison is declared absurd, and moxæ are absolutely prohibited. Should they be used, there would follow dizziness, deafness, vomiting of blood, hectic symptoms, night sweats (which he calls thief sweats, probably because they come like thieves in the night). Evidently the author believes in a relation of syphilis with tuberculosis.

Syphilis is more frequent among southern populations than in the north; it is more frequent near the sea than in the mountains, in the cities than in the country, among the poor than among the rich. He concludes from these facts that the cause of the disease must have some relation to heat and moisture; the lower class in Japan mainly live in swamps.

He claims originality for his treatment of tertiary syphilis; the other treatments contained in the book are taken from various authors.

He advises to open an inflammatory bubo. For a hard bubo

<sup>1</sup> 1122 B.C. to 314 B.C.

he gives purgative medicines ; for a discharging bubo he prescribes animal broths and chicken.

He mentions various secondary eruptions ; the ordinary form is the *willow plum* ; some are shaped like the nail of a drum ; some like a yellow pea ; some like the cotton flower ; some like purple grapes ; some like fish-pocks (chicken pox), etc.

Inherited syphilis resides in the bone, and the contagion of syphilis in the skin.

Tertiary syphilis is called *tangled poison* ; it is mostly incurable. The tangle occurs in the muscles and bones, when the secondary stage has not been properly treated. Muscles contract, paralysis occurs, cough, night sweats, diarrhœa, swelling of joints, discharge of pus from bones. The whole appearance is that of consumption. Lumps are formed in the neck, deafness occurs ; the eyes are inflamed, the sight is lost, the cartilage of the nose falls out, the tongue cracks and putrifies, pus comes from the throat, the voice is lost, deglutition becomes impossible, insanity steps in, swellings form on the bones, the skin resembles that of a bull, necrosis and caries of the leg bones, the sores having a purplish black color.

He mentions syphilis contracted by contagion from mouth and nose instead of by the ordinary route of chancre and bubo. It is the same syphilis, says he.

The following symptoms of tertiary syphilis are incurable : hectic fever, emaciation, hard cough, high temperature and great nervous excitement, like mania. He refers to the " Southern barbarian " method of dealing with the disease, introduced by the Spaniards and Dutch in the sixteenth century. It is good, says he, in chronic cases.

His own remedies are the following : Celestial pills, which contain calomel ; eliminating pills, which also contain calomel ; silver-nitrate pills, which contain mercury and nitrate of potash ; five-element pills (having some relation to the sacred elements, wood, fire, metal, earth, water), which contain calomel ; yellow<sup>1</sup> eliminating powder, which contains calomel ; precious-dew powder, which contains calomel ; and another medicine which also contains calomel.

The author treats of true and false gonorrhœa. It is described, he says, in the Kinki (golden chest), written 200 A. D.

Other diseases mentioned in the book are piles, ringworm, lumps in the neck, eruption of the scrotum (wet like the nose of a bull), orchitis, perineal abscess, strictures, ozœna, paralysis,

<sup>1</sup> Yellow is the sacred color.

hemiplegia, consumption, and a form of syphilis which looks like leprosy. In this latter disease eruptions succeed each other; there is anæsthesia; hands and feet crook, eyebrows and hair fall out.

There is a paragraph on syphilitic salivation.

Some forms of syphilis may easily be mistaken for beriberi, rheumatism; therefore, let the doctor be careful in his diagnosis.

Syphilis affects women more rarely than men; this is accounted for by the poison escaping with the catamenia.

Syphilis in pregnancy is very severe.

Warm spring baths are recommended in the chancre stage of syphilis, in ringworms, and whenever the disease has not lasted long. A syphilitic or a leper, after taking such a bath, should feel more pain than before; it is a good sign. If he purges after such a bath it is also of favorable augury.

Poisoned diet—he means a diet unfavorable to the patient—is advised as being unfavorable to the poison of syphilis. One poison drives the other out; *similia similibus*.

Calomel is not recommended in the beginning of syphilis.

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#### A CASE OF MYCOSIS FUNGOIDES.

BY

R. A. McDONNELL, M.D.,

New Haven, Conn.

VERY few cases of this disease having as yet been seen in America, and the affection itself being one of which comparatively little is known, the following report is respectfully submitted as a contribution to our knowledge of its clinical nature.

Mr. G., a farmer, aged 62, came to me on May 20, 1893, presenting the following conditions: on the left side of the face, near the angle of the jaw, was a circular protuberance with a base approximately the size of a quarter-dollar, and a cauliflower-like top about as large as a trade dollar; the excrescence projected about two-thirds of an inch from the surface of the skin, and was quite soft and apparently without deep attachments. Its top was uneven, presenting the appearance of exuberant granulations, and was partially covered by a thin, shiny layer of epithelium, while the denuded part secreted a colorless, slightly offensive fluid. In the immediate vicinity of this



tumor were scattered irregularly shaped patches of small size, covered with yellow crusts, on removal of which they presented the appearance of a very sluggish, subacute inflammation; a scant secretion of colorless fluid was noticeable from some of these patches also.

Some places had not gone as far as desquamation, but appeared red and inflamed. These conditions covered pretty much the whole of the left side of the face below the malar bone, and the left ear was also involved.

The patient next called my attention to a spot of the area of the size of the little finger nail on his right cheek, which, as he said, looked exactly like the original patch from which the protuberance started. It consisted of several yellowish white pearls the size of grains of rice, covered by a thin layer of reddened, shiny, atrophic looking skin; the patch was very slightly elevated above the level of the surrounding surface. Neither the glands under the jaw, the cervical or the axillary were enlarged.

The history of the case was as follows: until four years ago the patient had always enjoyed good health. About that time he had erysipelas of the face, and after recovery from this he soon noticed little sores breaking out on his face, these later becoming moist, and finally covered with scabs; they failed to heal, however. He received ineffectual treatment at this time from several physicians for "eczema." Shortly afterward a patch appeared on the site of the present tumor, which he described as exactly similar in every way to the present small patch on his right cheek. This remained quiescent until about six months before he came to me, when it, in common with the other patches, began to itch very annoyingly, and he scratched it a good deal. It then took on a very rapid growth, until it reached its present size. It still itches a good deal, and when he scratches it the blood flows quite freely, giving him some relief.

The differential diagnosis lay between frambœsia syphilitica, actinomycosis, sarcoma cutis and mycosis fungoides.

Frambœsia syphilitica was excluded by the absence of history, glandular enlargement, scar on penis and of any appreciable effect from two weeks' administration of tannate of mercury.

Actinomycosis was rejected after a very careful microscopic examination for the characteristic rays, and from the clinical fact that the disease seemed totally separate from the bone.

not arising from a carious tooth, as is common in actinomy-cosis.

Sarcoma cutis is very rare as a primary affection, and would fail totally to account for anything but the tumor in this case.

The treatment adopted was at first a night salve of ten per cent. resorcin, and a day salve of two per cent. salicylic acid, with Pil. hydrarg. tannatis aa .06, one t.i.d. In a week the tumor projected not quite so far, several layers having been shed, but the other patches were unaffected. The mercury was continued, and pure resorcin powder applied alternately at night with ten per cent. resorcin paste, the patches being washed before application with soap and water. Another week showed a slight further decrease in the size of the tumor, but the smaller patches were unaffected. The third week, the patient was put on fifteen drops of Fowler's solution daily, and a ten per cent. pyrogallic salve given at night, as the patient decidedly refused an operation, which was advised. The pyrogallol worked better than the resorcin, as the tumor shrank distinctly in one week, and the raw, angry looking patches on the cheek took on a healing process, some having become entirely well. Quite a good deal of pain was complained of in certain of the patches, and this I lay entirely to the reaction induced in them by the arsenic, since before this they had been almost entirely painless.

June 24th. Improvement is marked in all patches, but the tumor, which has remained about stationary; the deeper structures around the tumor seem to be slightly involved now, but operation is refused. The arsenic was continued, and resorcin powder alternated with pyrogallic salve at night.

July 8th. Patient returned to-day with tumor slightly larger than last time, and the other patches about stationary. He is decidedly discouraged, though he has gained in weight since beginning treatment, and the patches are at least somewhat smaller than at first. He suffers considerable pain now, so, to relieve his discouragement, a five per cent. menthol wash was given, and a forty per cent. salicylic acid paste, with five per cent. carbolic acid added to mitigate the pain.

July 15th. For the past week Mr. G. has been suffering great pain in his face, though he does not lay it to the salve. The tumor has not noticeably changed its appearance, though the subcutaneous tissues in the neighborhood are evidently involved. At this point the patient withdrew from observation.

On reflection, I am now convinced that the best treatment



for this case would have been total extirpation of the tumor and the nodules with the knife, and a most thorough curetting of the erythematous patches with the sharp spoon. I am confident that this would afford the best chance for recovery from a disease, which, for the time at least, appeared so purely local.

312 Elm Street.

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CLINICAL NOTES ON SKIN DISEASES.<sup>1</sup>

BY

W. F. BREAKEY, M. D.,

Ann Arbor.

As the Society very properly concerns itself with the facilities for instruction and the thoroughness of teaching in medical colleges where graduates are annually added to the profession to be co-workers and competitors with us in practice, I assume that its members, both as physicians and citizens giving professional and material aid to the University of the State, would be interested in hearing something of the work done at the Skin Clinic in the Department of Medicine and Surgery of the University of Michigan.

On sending the above title to the secretary, I had expected to give detailed reports of a few cases of special interest, but I am unable to secure some necessary data by correspondence in time for this paper, and must therefore content myself with a brief statement of the number, character and variety of the more important cases appearing at the weekly clinic, referring only in a general way to particular cases or classes. The relative number of each, if all minor cases were counted, would correspond to larger tabulated lists, as shown by the following partial record.

Acne, simple, vulgaris, pustulous, and indurated, 14; alopecia, 3; chromophytosis, 5; dermatitis, 4; eczema, all varieties and regions, 33; epithelioma, 3; erythema, 5; fibroma, 2; ichthyosis, 1; keloid, 3; keratosis, 2; leucoderma, 3; lichen ruber, 1; lupus erythematosus, 4; vulgaris, 3; nævus vascularis, 5; pigmented, 4; pilosis, 4; psoriasis, 11; rodent ulcer, 4; scabies, 3; seborrhœa, 12; syphilis, 17; sycosis, 4; tinea barbæ, 2; ulcer, indolent, varicose, etc., 10; urticaria, 4; zoster, 3.

It should be stated that the lectureship on Dermatology and

<sup>1</sup> Read before the Michigan State Medical Society, 1893.

Syphilology was established but two years ago ; also that carcinomata of the skin, a considerable number of epitheliomata, and rodent ulcers were treated at the surgical clinic, and numerous cases complicated by syphilis were treated in the clinics of surgery, practice, gynecology and nervous diseases.

A considerable number of cases were prevented from appearance at the clinic by reason of lack of room in the hospital, as, when the wards are crowded, if any have to be refused, naturally the first would be those patients with marked disfigurement, repulsive or offensive in appearance, while the subjects of infectious or actively communicable diseases are not admitted, there being as yet not sufficient room to afford them a separate ward.

Many of these cases were of patients who were, however, seen the same as those in the hospital during a period of weeks, or until recovery was complete, or so far advanced that they could be safely discharged, giving opportunity for repeated examinations and the study of cases of difficult diagnosis by reason of polymorphous condition of single cases, or complications of two or more co-existent diseases in the same patient, as also for observing the application and effect of treatment in different phases and stages of the same case.

Numerous cases of eczema complicated with acne, with seborrhœa, or with psoriasis, and parasitic disease and syphilis were found with any or all of them.

Many cases were of particular interest because of the existence of both constitutional and dermal diseases, the former often a cause of the latter and sometimes a result, the great majority needing general medication as well as local treatment, thus emphasizing the fact that pathology of diseases of the skin is no narrow specialty, but so intimately connected with general pathology that one can only hope to achieve success in this field by a previous considerable familiarity with the broad domain of general practice.

The field, however, is ample for cultivation and, great as has been the progress in the whole realm of medicine, will reward the diligent laborer. Probably no department of medicine has received more interest or made more advance in the past decade. Its literature has increased tenfold. The great aid and facility which experience confers, however, in diagnosis and in the application of local treatment of itself furnishes a sufficient reason for the maintenance of the field as a separate specialty in medical practice

Numerous instances were furnished of psoriasis occurring with rheumatism or gout following in its wake and cured or greatly relieved by appropriate treatment for the rheumatism.

Locally, pyrogallic and salicylic acids or chrysarobin unguents were found effective in many cases.

Many cases of eczema, both of infants and adults, made good recoveries with internal use of cod-liver oil and tonics, and appropriate local treatment.

Acne and seborrhœa were numerous, and, as a rule, chronic cases did better with saline laxatives, care in diet, sufficient exercise and puncturing the pustules and indurated lesions.

Several cases of nævi, vascular, pigmented and pilosis, were successfully treated by electrolysis and epilation. Two of the latter cases, nævi pilosis, covered such extensive areas as to make this or any treatment impracticable.

A keloid tumor, about the size of a half-dollar, with an elevation somewhat like a thimble or blackberry, was removed from the sternal region of a patient about forty years of age. The history of the case from record is as follows: Occupation, laborer; father healthy; mother has an epithelioma on face, brothers and sisters all being healthy; patient has had usual diseases of childhood, also small pox; his general health good; no history of traumatic origin.

About ten years ago a boil appeared on the sternum. It remained very sore and painful for three or four months, then healed, leaving a lump about the size of a pea covered with normal epithelium. Four years ago it began to grow slowly, becoming dark red in color. In a year's time it was the size of a hazelnut, when he incised it with a razor which caused it to grow faster. A year ago it was the size of a hickory nut, when a physician removed it with a knife. Before the wound healed the disease returned in the line of incision, and is now about the size of a half-dollar. Notwithstanding the predominance of opinion against operative treatment of keloids, the growth and the history of this one tending to support such opinion, the case seemed favorable for the removal of all the diseased growth and, therefore, hopeful of good results.

The skin and tumor being still movable over the sternum, an elliptical incision was made extending considerably above and below the tumor, removing it with subjacent connective tissue, and loosening the skin on either side so it could be slid together, the interrupted sutures holding it being relieved in

large part of strain by adhesive straps, with broad ends adherent well back on chest, with narrow isthmus where crossing coaptated edges between sutures, the straps left in place several days after removal of sutures supporting skin until union was firm. Union occurred by first intention and no recurrence of disease when last heard from some months ago.

The rule against removal or active operative interference with keloid is doubtless correct where it is small, not causing trouble nor pain, or when it is not feasible to remove all diseased tissues, or where a wound must be left to close up by granulation; but when the tumor is painful, growing or not spontaneously receding, an entire growth can be removed and the wound covered with healthy skin, it seems as proper treatment as if the growth were malignant.

Keloids of face following in scars from sycosis and trichophytosis barbæ may spontaneously disappear or grow less. Some cases of this kind occurred.

The numerous cases of falling of the hair, more frequently observed than usual this past Winter, in private cases, particularly in young men, students mostly, not marked cases of alopecia, without canities, not hereditary nor syphilitic, suggest a number of inquiries and reflections that might be profitable to consider.

Generalizing only, one might say, it is not complimentary to our civilization that the savage has better hair, and that he does not get gray or bald so early or completely. It is not complimentary to the sterner, if not superior sex, that women retain their own hair, however much more skillfully they conceal its defects, longer and better than men.

And the inquiry naturally suggests itself—Do men, particularly young men, have their hair cut too frequently and too much? Are their heads kept habitually too warm or too cool? Is the head washed too much or too little? Is the seborrhœa which causes much of the trouble a result of too many or too few applications? It is sometimes curious and would be amusing, if not so serious, with what confiding trustfulness the average citizen submits his head to the hands, and sometimes to what is more dangerous, the advice of the tonsorial artist. He allows his head to be harrowed and hatched with a stiff bristle roller, and then “shampooned” (?) with the compound on which there is the largest commission, and then the hair singed (?) to keep the juices from running out of the newly cut ends of the hair shafts.

The victims who have to endure the monologue of the



knight of the razor and shears, while their mouths are too full of lather to protest, are not the only sufferers at his hands.

And what is, and may be, a great luxury—hair-dressing—is liable to become a questionable, if not an unsafe indulgence. These ideas are somewhat random and speculative, perhaps, but this subject of hygiene, and care of, as well as the diseases of the hair, is of the first importance.

A considerable number of cases of syphilis have been treated at the clinic. I may briefly refer to one which, in my opinion, aptly illustrates the propriety of adherence to the rule not to cauterize a primary lesion nor medicate, specifically, a case of supposed primary syphilis.

A male patient, aged nineteen, with congenital phimosis and three small indurated sores on cutaneous surface of a puckered prepuce at its mucous border, and a slight muco-purulent subpreputial discharge, gave the following history.

Had intercourse with a dozen or more different women for a year previous to August last, when he noticed a swelling in left groin, which increased to an oval-shaped tumor, two or three inches long, elevated about half an inch. Applied immediately unguents of mercury and iodine alternately, and took medicine internally; the buboes disappeared without opening. Had also at same time a discharge which was supposed to be urethral. In October or November following—he was not very exact as to dates—a sore appeared on mucous border of prepuce, followed by small papules which subsequently broke down and formed the additional sores described. Patient stated that sometimes in the intercourse the foreskin was stretched and cracked, leaving small fissures that bled; affording excellent conditions for what, in my opinion, was a case of multiple infection. Had no rash that he knows of except a few pimples on his face and forehead.

It was impracticable to determine in the only examination made—on account of the puckering of prepuce and the phimosis—whether any part of the subpreputial discharge was urethral. Microscopical examination failed to discover any gonococci. Had fever and pain in his bones at time of and following the buboes, which was relieved by constitutional treatment at that time. Was without treatment for three months, and the pains and general low feeling had returned.

He was treated expectantly for a week, and then, on the belief that his was a case of delayed and irregularly developed

syphilis, in which the ordinary symptoms had been obscured by premature local and general treatment, the sores were treated by using an ointment of hydrag. am. chloride, and a mixed treatment internally of mercury and iodide of potassium. An immediate improvement appeared in condition of sores and relief of pains in bones and general symptoms previously complained of.

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## Correspondence.

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### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

**Upon the Animal Origin of the Trichophytoses of the Beard.**—As I have already said in my former letters, Dr. Sabouraud follows up his accurate series of studies upon the trichophytons with a tenacity worthy of the greatest praise.

The last communication to the French Society of Dermatology, on the 20th of July last, is among the most interesting. I am going to analyze it with some details, for his researches are truly original and revolutionize this whole corner of cutaneous pathology.

The author commences by recalling that the analyses of the trichophyton diseases have up to the present time demonstrated to him three great facts: 1st, there are two trichophytoses, the one caused by the micro-trichophyton, the other by the megalo-trichophyton; 2d, the trichophytoses caused by the megalo-trichophyton lead to the study of numerous cases caused by different parasites; 3d, these parasites of the same family—some very different from others, but the others very closely related—are both of fixed species, having unchangeable characters.

Furthermore, his most recent investigations tend to prove to him that all these species of trichophyton, having large spores, should be ranged in two distinctly separate families: 1st, the megalo-trichophyttons of animal origin, which are characterized under the microscope by the fact that the parasite invades not only the hair to its very root, but also the epidermic sheath of the follicle outside of the hair, and even frequently the elements of the surrounding derma; 2d, the megalo-trichophyttons of human origin, which are, on the contrary, characterized under the microscope by the fact that the parasite is exclusively limited to the hair, and that it does not pass beyond its external cuticle.

I. The animal megalo-trichophyttons group themselves in three perfectly distinct categories: *a*, the first comprises the trichophytoses deeply seated in the skin, giving white culture—the type of this is given in the megalo-trichophyton *pyogenes* of the horse; *b*, the second comprises the megalo-trichophyttons of superficial situation in the skin, disseminated, moist and giving a yellow culture of vermicular form—the type of this is given by the trichophyton of the calf; *c*, the third comprises the dry trichophytoses in the form of *ichthyosis pilaris* and giving rose-colored cultures, whose development is such a slow one that they might be called the trichophyttons of



slow culture. Dr. Sabouraud believes that this latter type originates from birds.

II. The megalotrichophytos of human origin belong in two categories quite distinct: *a*, in one the parasite is characterized by long chains of mycelium, uninterrupted, which are not broken by splitting up the hairs; this is the megalotrichophyton of resistant mycelium; its culture is crateriform; *b*, in the other the parasite is characterized by spores in chains so fragile that they break apart, cell by cell, in their preparation. These are the megalotrichophytos of fragile mycelium; their culture is acuminate. Furthermore, each of these groups comprises different species, but very slightly different, having close affinities, shown: 1st, clinically, by the objective resemblance of the lesions which they cause; 2d, histologically, by the morphological resemblance of their parasitic elements; 3d, in culture, by the resemblance of their action and aspect; 4th, from a mycological point of view, by their botanical resemblances.

The author dwells especially in this memoir on the study of the megalotrichophytos of animal origin. These trichophytoses are met with in man five or six times in a hundred cases of *tinea tonsurans*, with large spores in infants, and about in thirty per cent. of the cases of trichophytosis of the skin in non-hairy regions. As to trichophytosis *pilaris* of the beard the seventeen cases which he has observed were caused, without exception, by animal trichophytos. We see that this last fact is of capital importance, the beard thus seeming to be the place of election of animal trichophytos. The author calls trichophytosis of the beard those cases which have their seat not only in the epidermic elements, but also in the adult hair of the region. Now, every time that we have to do with an instance corresponding to the preceding definition the parasite has been a trichophyton of animal origin and never a human trichophyton. Each time, on the contrary, that there was an epidermic trichophytosis alone of the beard, and consequently resembling the superficial trichophytosis of the smooth regions, it was a species of human origin that caused the disease. The author studies in detail the three great varieties of trichophytosis *pilaris* of the beard, which he has distinguished—

*A. Trichophytosis of deep situation. Sycosis.*

Dr. Sabouraud gives the name of trichophytic sycosis to the only two trichophytoses *pilaris* of the beard which are accompanied by agminated suppurative folliculitis in plaques which have ordinarily a rounded form. They have a variable aspect, and the author enters into details of description regarding them which it is not necessary for us to insist upon here, but they always have the following characters: 1st, the element of the lesion is evidently a folliculitis; 2d, it is the agmination of neighboring points of folliculitis which produces the sycotic plaque; 3d, the lesion goes on to suppuration of the invaded follicles without the symptoms of heat and pain corresponding with the very inflammatory appearance of the lesion.

The hairs of the diseased region are often dead and detached at their base without having been invaded by the trichophyton.

The most characteristic trichophytic hairs are ordinarily found at the circumference of the lesion; they have features of all trichophytic hairs with large spores; they are thick, short and gray colored.

On microscopic examination of all of these hairs we observe at once this constant characteristic, that not only is the hair invaded, but that its

whole follicular sheath is as though filled with elements of mycelium and of agminated spores.

Furthermore, one may find some differences, according to the case, in the size of the spores and in the resistance of the mycelium—differences which correspond to the multiple species of the trichophytic type having large spores, a deep seat and giving white cultures.

On the other hand, in a given case all the hairs of a lesion present an identical aspect.

The cultures of these trichophytos are very vivacious; on beer must at one-fifth strength they cover a surface of one square decimeter in five weeks.

The adult culture is of the whiteness of snow, forming one or two regular concentric circles, with a central downy part and a powdery periphery of fine divergent lines. These are those species of white cultures which present the conidian appearances described by Neebe and Furthmann.

These trichophytos which give birth to the sycotic forms of trichophytosis all come from the horse.

B. *Trichophytosis of the beard having the form of disseminated, moist dermatitis.*

This second form is, above all, characterized by the dissemination of the lesions in little plaques; there are from two to ten or twelve affected points over which the epidermis is exfoliated as though by the application of a blister or by a light burn. Over their surface is seen a slight serous exudation, and sometimes a hardened drop of a golden yellow color is attached here and there to the base of a healthy or diseased hair.

Dr. Sabouraud considers these lesions as of epidermitis. The dermatitis is scarcely sensitive to the touch. At times a minute follicular abscess may be formed.

At times, but always after a certain period of evolution of the disease, points of induration are seen to appear which are hypodermic, entirely isolated and rarely end in the formation of the rudiments of abscesses, which are not trichophytic, as in the preceding form, but are microbial and caused by the staphylococcus aureus.

The diseased hairs are numerous but scattered; they are thick, grayish, and break on epilation. It is not rare to observe upon the patient himself or upon some one of his associates, in confirmation of the diagnosis, a ring of trichophytosis of quite large dimensions, presenting at its periphery the same epidermitis and the same exudate.

On microscopic examination the hair is much less invaded than its follicular sheath. In the elements of the follicle are found an abundance of mycelial fragments, chains of ovoid spores, with double outline having a dimension which varies from 9 to 11  $\mu$ .

The culture of these trichophytos on gelose or must of beer must form around a small central accumulation a powdery areola of grayish yellow, from which soon shoot out arborescent striæ of elegant clover-leaf form. Then, at the distance of a centimeter from the center, a regular corcentric powdery zone forms of the same color, from which again go off the arborescent striæ.

These varieties of trichophyton have been seen and followed up by the author in the horse, but he believes that ordinarily it comes from the calf.

C. *Dry trichophytosis of the beard in the form of ichthyosis pilaris.*

The person affected with this form does not usually complain of any-

thing more than a little pruritus. The skin offers a very pronounced roughness, each cone about the hair is dry, slightly scaly, and the hair emerging from it is broken off at three or four millimeters from the skin. It is surrounded by a visible epidermic case, forming a little collar at about a millimeter above its point of exit. The hair is thick, slightly grayish, and breaks in being epilated. Histological examination shows that the parasite occupies not only the hair, but its sheath as well; that the hair is invaded by linear series of large, round spores with double outline, filling it completely. In the sheath, on the contrary, the mycelial filaments, much more slender than the chains of spores, are, nevertheless, more solid. The mycelium of the sheath has a curvilinear undulating direction, rather transverse to the great axis of the hair. This is the trichophytic group whose culture is the slowest upon test culture media. Upon the gelose of beer must it forms a silky tuft of white aerial down; upon the dorsal surface of this the center is marked by a permanent black spot; it enlarges with the same features, and at the end of about a month it presents striated folds; its surface becomes of a delicate rose, while in the deeper parts it is of a raspberry violet. Microscopic examination of the cultures shows that the cluster is short; that the pediculated spores are disposed one by one over the whole length of the adult mycelial tubes, and that the wreaths of spores are disposed regularly around the mycelial septa. The author believes that these trichophyton are of fowl origin, but it is not yet absolutely demonstrated.

Mr. Sabouraud remarks, on terminating this work of so much importance, that it results from the preceding facts that the trichophytosis pilaris of the beard in man seems to come directly or indirectly from the mediate or immediate inoculation of animal trichophyton, and that, in consequence, trichophytic sycosis forms an affection apart and quite distinct in symptomatology and etiology, and that, therefore, the old conception of parasitic mentagra, a morbid species differing from tinea tonsurans, was a true one and should be re-established.

**Hydrotherapy in Dermato-Neuroses.**—Dr. Beni Barde has just confirmed and completed what we have already said on this subject in a former article. In a recent communication to the Academy of Medicine he recalls the fact that it was our eminent and regretted master, Dr. E. Vidal, who first made use of temperate douches of light percussion directed for a few minutes (three to six) upon the sides of the vertebral column, in order to combat the reflex excitability of the spinal cord, to which he attributed certain functional or trophic troubles of the skin. This procedure has been taken up and modified by Dr. Jacquet, and later by ourselves. Dr. Beni-Barde has frequently applied it in recent times, and has in this way been enabled to cure several cases of lichen planus, two cases of chronic circumscribed neuro-dermitis, chronic lichen simplex (E. Vidal), several cases of prurigo and two cases of generalized eczema. It is the temperate douche in temperature varying, according to the subject, from 33° to 38° centigrade and moderately percussive, which agrees best with the majority of patients affected with dermato-neuroses. One a day is given in cases of moderate intensity, two daily when the nervousness is very well marked, more frequently even, if needs be, if the exasperation becomes extreme. The author has seen hospital cases affected with lichen planus cured by this medication

much more quickly than patients in private practice. He believes it is because the former are, in general, persons in whom the nervousity plays a small part, and who ordinarily present no hereditary nervous predisposition. The other class, on the contrary, are constantly subjected to causes of enervation and of irritation because of the media in which they live, their professional and social obligations, their preoccupations and their lack of strict hygiene. In the application of this treatment it is necessary (as Dr. Benibarde very justly says, repeating what we have already written upon the same subject) to know how to adapt this therapeutical measure to the capacity, tolerance and sensitiveness of the patients. Some can stand cold douches, but these can only be used with great prudence, and only after the disappearance of the pruriginous symptoms, otherwise one risks seeing reappear the congestive attacks with the itching which accompanies them. Certain patients, subjected for a long time to sedative treatment—that is to say, douches at 35°—instinctively demand a gradual elevation in the temperature of the water. This can be done without fear, for the hot douche can, according to the manner in which it is administered, tone or calm the patient, and it does not expose to a disagreeable return of the dermatoneurosis. There can then be substituted in some cases for the hot douche even the vapor douche, which is applicable to those who dread the effects of the percussion. As adjutant means the author has employed, to combat itchings and neuralgias of the anus, sitz baths of flowing water, the perineal douche, and especially the hemorrhoidal douches.

**The Dermatoses of Alimentary Origin.**—Dr. Juhel-Rénoy, following several other French authors and especially Netter, Sabit and Polin, has just made a study of alimentary poisoning of meat origin. Alongside of the gastro-intestinal form and of the typhoid forms, which may appear after such accident, there is a third form very interesting for the dermatologist. This is the eruptive form. The cutaneous manifestations of the alimentary poisoning of animal origin are slow, appearing several days after the ingestion of suspected food, and they can assume a variety of aspects. In one instance it will take on the appearance of erythema in the form of macules, sanguinary spots, papules, or violaceous vesicles. Again, we have presented urticarias, scarlatiniform eruptions roseola or variola-like eruptions, etc.

The cutaneous manifestations appear symmetrically upon both upper extremities, and then invade the face and trunk. They pass through rapid evolution and appear in successive crops, leaving often pigmentation behind. Hence every time in practice one has to do with a dermatosis a little strange in appearance, preceded by gastro-intestinal symptoms, such as diarrhoea, vomiting, pains in epigastrium, or even generalized severe phenomena of typhoid form, one must be on guard respecting alimentary intoxication and act accordingly.

**The Employment of Sulphurous Waters in the Normal Treatment of Syphilis.**—We have here, as is well known, a practical question of the utmost importance and one much discussed. It is also well known that certain authors do not hesitate to consider treatment by sulphurous waters as dangerous in syphilis. Dr. Dresch, who has just published a short study of the question, thinks he can affirm, in basing his belief on the numerous works of former writers, Colonier, Astrié, Garrigon, etc., and upon his own practice, that the sulphates, and especially the sulphites and hyposulphites



which penetrate the blood and the meshes of the tissues, dissolve the albumino-mercurial compounds which fix the salts of mercury in our tissues and thus renders their elimination easy. This elimination is also stimulated at the same time by the increased activity impressed upon the cutaneous, urinary and mucous excretions.

The benefits from sulphurous waters in the treatment of syphilis are thus, according to him, manifold. They have, first of all, the advantage of eliminating the mercury accumulated in the organism by the treatment called that of extinction, generally adopted in France according to the principles laid down by Fournier. Now, this mineral poison is not without its serious inconvenience, for the various organs which it impregnates and of which, perhaps, it favors sclerosis as much as the syphilis itself, or the various diatheses which the patient may present.

Furthermore, in causing this mercury in the tissues to move along, it may again enter the circulation and produce upon the economy the same physiological and therapeutic effects as when first administered. That which proves the reality of this extraordinary statement is that sulphur water, taken at the same time as mercury, prevents salivation, and is, on the other hand, capable of itself alone to provoke salivation in those who have taken mercury before the thermal cure, and this after a considerable lapse of time from the cessation of all mercurial treatment. Thus, according to the author, should one not carry out a mercurial treatment at sulphur baths in those alone who cannot tolerate mercurial preparations? Otherwise, to give at the same time mercury and sulphurous water constitutes, according to the author, a veritable nonsense, for in organisms capable of supporting mercury the elimination of the medicine is accomplished in their case so extremely fast that the organism is in no wise impregnated. We must, on the contrary, let the sulphurous treatment follow the specific cure. In this way we get out of the mercury all it can give in this coming and going, as it were. We establish in the organism from without inwardly medication by mercury alone, and from within outwardly sulphurous medication alone—medication of elimination. Sulphurous waters can then render immense service in severe and rebellious cases, permitting of a cure by mercury and causing habituation to the drug to cease. When the ground has been in a way renewed by the sulphurous washings a new anti-syphilitic treatment may triumph over accidents which had previously resisted all medication.

Paris.

L. BROCC.

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## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

#### 227TH REGULAR MEETING.

DR. ALLEN, *President, in the Chair.*

**Case for Diagnosis.**—DR. CUTLER presented a woman with a swelling at the entrance of the nose. She was married, had children, and did not give a history of syphilis. The tumor in the nose began as a small, shot-like body at the entrance of the left nostril about eight months ago, and gradu-

ally increased in size until now it nearly blocks up the nasal opening on that side. The tumor is of a dark red color, and although firm, has a semi-solid consistency at the centre, as though it was going to break down at that point. Although it looks inflammatory, the patient states that it neither itches nor pains. A second tumor of greater consistency is found above the left eye, without any material changes in the skin itself.

DR. SHERWELL would not give a positive opinion, but would try anti-syphilitic treatment.

DR. FOX could not imagine what else the affection could be but syphilis, although one might think of lupus or of rhinoscleroma. He would not rely at all on the absence of a history. He had but recently seen a case of a recent maculo-papular syphilide, in a man who pleaded sexual purity, and upon whose body not the slightest trace of a primary lesion could be found.

DR. LUSTGARTEN remarked that tertiary lesions of this kind were very slow to break down.

DR. BRONSON did not consider the affection a specific one; he never saw syphilitic lesions that lasted so long without breaking down. He thought a diagnosis could be made only by microscopical examination. It was possibly a case of sarcoma.

DR. KLOTZ believed in the syphilitic nature of the affection, and would not exclude that disease on account of the duration of the lesion. He mentioned a case of a woman whom he had under observation for over four years, for a swelling of the nose, which at one time had been considered as of carcinomatous nature by a prominent surgeon, who had intended to operate upon it. The presence of a superficial ulceration of the soft palate and the absence of the uvula had induced him to try anti-syphilitic treatment in different forms, internally as well as inunctions and injections of calomel, which always had been followed by considerable improvement, so that at the present time the nose had again assumed its natural shape. He had some doubts about the syphilitic nature of the case, but the symptoms did not agree with those of other diseases, particularly with those of rhinoscleroma.

DR. ALLEN said that the situation of the lesion, but not its color, suggested rhinoscleroma. He could not agree with Dr. Bronson upon the significance of the persistency of the lesion without breaking down, since gummata at times persisted for months together.

DR. MORROW said that in his experience gummatous tumors could persist very long. He watched for four or five months a small tumor on the canthus of the left eye without the slightest sign of breaking down. Finally, the tumor became soft, was scraped out and healed.

DR. TAYLOR thought that Dr. Bronson's position was not so untenable. There was a great difference between gummata under the skin and those on the edge of mucous membranes and the skin; in the latter position there was a greater tendency to softening.

DR. FOX said that the nearer to the date of infection a gumma developed the more liable it was to break down; in a person of robust health a gumma may remain unchanged for a very long time.

DR. MORROW stated that in the case mentioned by him infection had taken place sixteen years previously.

DR. SHERWELL believed that often there was a certain sort of conservatism of nature or benignity of course in syphilis in women, who had ac-



quired the disease during the puerperal state, the infant in utero seeming to receive the greatest shock, as it were. The women often did not seem to suffer from secondary manifestations, a slightly impaired general health being the only sign, until late, when gummatous lesions and nervous syphilis occurred. Such cases had occurred many times his experience, as far as he could trace out histories.

DR. ELLIOT thought it was not so unusual to find gummata that remain unchanged for a long space of time. The large papular resolving syphilide, which was essentially of gummatous structure, might last for months. The nodular gummatous infiltration on the legs, which has been described by Dr. Taylor, ran a very slow and long course without breaking down. Ulceration depended on the intensity of the process, as could be seen in periosteal gummata, some of which break down very fast, and others do not. The gummatous infiltration of the glands of the neck, cases of which had been published by Dr. Lustgarten, may also last very long before any softening occurs, as he had himself lately observed in a case.

DR. TAYLOR remembered a case of Dr. Parker's of a tumor of the lip and the orifice of the nose, which greatly resembled the present one. The tumor was scraped out and healed; it proved to be a colloid one. He would advise to try the insertion of an exploring needle.

DR. CUTLER had thought that the diagnosis would be between rhinoscleroma, syphilis and perhaps sarcoma. The history did not favor syphilis, but that need not be taken much into consideration. The growth of the tumor had been very gradual. There is a certain sensation of fluctuation present, but he believed it to be deceiving. The tumor was too soft for rhinoscleroma. The growth above the left eye might be part of the same process that produced the lower tumor, but he believed it to be independent and of a different nature. As he believed the tumor of the nose was a syphilitic gumma, he intended to start the patient on a course of antisyphilitic treatment to-morrow.

**Case of Bullous Eruption for Diagnosis.**—DR. FOX presented a boy, fourteen years of age, small for his age, and sickly looking, with good appetite but a poor sleeper. He had an eruption similar to the present one at from five to seven years of age, and had been well ever since, until about three months ago, when the present attack began. There are five children in family, none of the others being affected in a similar manner. The eruption appears in blisters gradually increasing in size and becoming purulent. Some of the pea-sized bullæ contain clear serum, others have cloudy contents, and others purulent ones. They have a tendency to coalesce, shrivel as soon as contents are accidentally evacuated, leaving discs and irregular scalloped patches of pink, swollen, or slightly scaly skin. In July there was a large bulla on the right calf, the size of the mouth of a tea-cup, three-quarters inch elevated, and three inches in diameter. On the dorsum of foot there was a bleeding surface. The hands, tanned brown, showed collapsed bullæ as pink spots covered with a white veil; purulent bullæ on back of right hand, a few blackish crusts on right fore arm. Body free, pink patch of the size of a quarter on right cheek with small bullæ at margin. Palms and soles free, a line of vesicles at inner edge of left arm. The denuded patches cause considerable pain.

DR. SHERWELL considered the case one of dermatitis herpetiformis. We

meet, he said, with very few cases of bullous eruption, where the inflammatory area is almost entirely absent. These are, perhaps, the only ones to be considered as true pemphigus. The case presented to-day he would not call pemphigus, on account of the redness and generally marked erythematous condition in and around the circumference of the bullæ.

DR. ELLIOT would not make the diagnosis of dermatitis herpetiformis. The disease always appeared primarily on the extensor surfaces of the extremities or on the body in a symmetrical manner, and only later on the volar surfaces.

By the term herpetiform, he understood that Dr. Duhring had intended to signify the neurotic nature of the disease, not the character and groupings of the lesions.

He would like to hear from Dr. Fox the difference between hydroa and other diseases, since so many different affections have been thrown under the name of hydroa.

DR. CUTLER thought it was a case of impetigo contagiosa. He remembered to have seen only one case of hydroa, and that with Dr. Taylor in Bellevue Hospital. In this case there was reinfection constantly taking place. The case would improve under treatment, but would soon spread again when the treatment was discontinued; the lesions would appear only on parts which the child could reach with the fingers.

DR. FOX stated that he had made inoculations, thinking of the possible infectious nature of the disease, but without effect.

DR. LUSTGARTEN opposed the opinion that this case was identical with impetigo contagiosa, which formed a superficial blister, drying up within twenty-four hours, spreading very rapidly and tending to heal spontaneously. Here the lesions were much deeper and becoming suppurative. He had observed Dr. Allen's case and one of his own, but could not prove their infectiousness. It is not a pemphigus acutus, and also not a typical case of chronic pemphigus, which is almost always an incurable disease.

He thought that the adherent of dermatitis herpetiformis might consider it as a form of this entirely too polymorphous clinical affection, but it would better deserve to be described under a special name. He considered it nearly related to chronic urticaria. In regard to therapeutics he would suggest pilocarpine, from which he had seen very good effects in chronic urticaria, every other day one-tenth of a grain in subcutaneous injection. Some new bullæ would follow but would dry rapidly afterwards.

DR. PIFFARD did not agree with Dr. Lustgarten as to the incurability of pemphigus, as he had seen several cases of genuine chronic pemphigus brought to a favorable termination by means of arsenic, as originally proposed by Mr. Erasmus Wilson. The means which he had found most useful in chronic urticaria was anything which would tend to the free production of perspiration. This, indeed, can be effected by pilocarpine, but the action of this drug was so often accompanied by unpleasant results that he much preferred the hot-air bath, either the regular Turkish bath or some home-made substitute.

DR. BRONSON agreed with Dr. Fox that the first sight of the case would suggest the diagnosis of a parasitic disease, but the fact that it had not healed within the last five months made the parasitic nature doubtful. The occurrence of a neuropathic disease of a circumscribed area was not so usual. The process to which Duhring has applied the name of dermatitis herpeti-

formis occurs in localized areas. He did not agree with Dr. Elliot that the selection of the name dermatitis herpetiform had reference to the nervous origin alone, but also to the grouping and form of the lesions, which were similar to those of zoster and other herpetic eruptions.

DR. ELLIOT stated that Dr. Duhring wrote to him personally that his intention in choosing the name was to indicate the neurotic nature of the disease. A large number of the lesions in dermatitis herpetiformis observed were not arranged in groups.

DR. PIFFARD did not approve of Dr. Duhring's appellation, dermatitis herpetiformis. The original significance of the word herpes was a creeping disease. Afterwards the term came into use in connection with grouped vesicular lesions, and the attempt now to give it a neurotic signification was wholly unwarranted.

DR. KLOTZ said in opposition to the remark of Dr. Elliot, that the presence of inflammatory symptoms around the bullæ was against the diagnosis of pemphigus. In regard to the remark of Dr. Lustgarten he held that pemphigus in children, at least, was not incurable.

DR. ALLEN said that it was not always possible to inoculate an affection, even if it were clearly a contagious one, and cited molluscum contagiosum as an instance of difficult inoculation, while it was readily transmitted. He would not agree with Dr. Lustgarten that impetigo contagiosa was always of short duration. The case presented by Dr. Fox was undoubtedly identical with one he had presented to the Society at a previous meeting. The disease was neither pemphigus nor dermatitis herpetiformis, but an original one. Too many different forms had already been included under the term dermatitis herpetiformis. He had not found that arsenic had much effect, but favored occlusive dressing.

DR. ELLIOT stated that he had treated Dr. Allen's case before he came under that gentleman's observation and made the diagnosis of impetigo contagiosa. In another precisely similar case, which he had treated with ichthyol, the lesions healed on all surfaces covered and protected, but new ones would appear on other localities not protected. He thought that there were two varieties of impetigo, the one appearing in the shape of bullæ filled with serum, which dried up into thin yellow crusts, and around this a bullous elevation of the epidermis occurred. By progressive extension in this manner the lesion might become quite large, ring-shaped or, by involution of some portions of the periphery, represent some segment of a circle and meeting with others constitute gyrate figures. The others consummate the same course but begin as flaccid pustular lesions.

DR. PIFFARD stated that in his opinion there was altogether too much said about so-called neurotic diseases of the skin. As a matter of fact, there were very few concerning which there was any evidence that they were due to a nerve lesion. Zoster we know to be caused by distinct lesions of certain ganglia, and we know that some of the phenomena connected with leprosy are due to nerve inflammation and degeneration, but beyond this we have little positive evidence connecting the skin with definite morbid conditions of the nerves.

DR. ELLIOT said that the bullæ of erythema did not always rise from reddened patches, but might originate like those of pemphigus.

## THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY, NOVEMBER 14, 1893.

DR. SAMUEL ALEXANDER, *Chairman*.

**A Case of Syphilitic Testis.**—DR. ALEXANDER presented a case of syphilitic disease of the testicle which, he stated, was of interest because of the difficulty of diagnosis when the patient first came under observation. On admission to the hospital one month ago the man's left testicle was hard and very much enlarged; both the body of the testis and the epididymis were involved. On the anterior surface of the testicle an ulceration existed, circular in shape and about the size of a silver dollar. This ulcer had clean-cut edges, which were undermined. Protruding from the base of the ulcer was a fungoid growth, which was a hernia of the testicle, covered with large granulations and secreting quite a copious discharge of thin, sanious pus. The history given was as follows: About eighteen months previously the patient had a sore on the penis which appeared six weeks after exposure. It was not followed by any secondary manifestations of syphilis. Shortly after the sore appeared he was put under treatment, and under the advice of a physician took potassium iodide for an indefinite period. The patient was a hard drinker. He had no further symptoms until six months before he came to the hospital, when a sore appeared on the scrotum; it was first like a small pimple; it then became scaly and rapidly enlarged. This ulcerated, but was never covered by a scab. The testicle proper became painful previous to the appearance of this sore, the pain, especially at night, being intense. This is still a very prominent symptom, keeping the patient awake at night.

DR. ALEXANDER said that while the history of the case suggested syphilis, the appearance of the ulcer and the feel of the testis was very suggestive of epithelioma. In order to clear up the diagnosis the man was put on specific treatment, and the improvement within four days was very marked. The granulations became smaller, the pain moderated and the fungoid condition began to diminish. At the present time the testicle has almost regained its normal size.

**Tuberculosis of the Bladder.**—DR. ALEXANDER also presented another patient, a man aged 56 years, who first came under observation in September, 1892, suffering from great frequency in urination, with tenesmus and pain. Eighteen months previously the man had had an attack of gripe, and since then he had suffered from cough and expectoration and other marked pulmonary symptoms, for which he was under Dr. Janeway's care. He had cavities in one lung and consolidation in the other. The bladder symptoms began twelve months before he came under Dr. Alexander's care. Repeated examinations of the urine showed pus in abundance, some *tripperfaden* and a large number of tubercle bacilli. The prostate contained a nodule about as large as a small bean and was sensitive to the touch. There was no history of any hæmorrhage. Deep urethral instilla-



tions of silver-nitrate solution (two to three grains to the ounce) were given at intervals of two or three days, and these afforded immediate relief to the pain. The frequency in micturition was also diminished. The patient, however, had a number of relapses and the pulmonary symptoms continued to advance, and in December, 1892, after consultation with Dr. Janeway, he was sent to Dr. Trudeau's sanitarium at Saranac Lake, where he has resided from that time until a few days ago. His weight, during that period, increased from 123 to 165 pounds, and his improvement in all other respects has been remarkable. While at Saranac Lake the instillations of silver-nitrate solution were continued. Both the pulmonary and the vesical symptoms have entirely disappeared. No tuberculine was administered.

In conclusion, Dr. Alexander said he has seen many cases of tuberculous disease of the bladder and prostate which were aggravated by deep instillations of silver nitrate, but in this instance the benefit derived from it was very marked. Instillation of bichloride of mercury (1-2,000, 1-3,000) was tried, but was not well borne.

DR. ALEXANDER exhibited a portable electrical battery, suitable for cystoscopic and urethroscopic work, which he has found very satisfactory. Its weight is about eighteen pounds. Including rheostat, its cost is \$30; without rheostat, \$25. It is made by Bartlett, of Brooklyn.

DR. R. W. TAYLOR said, regarding the first patient shown by Dr. Alexander, that it is rather unusual for the testis to become involved as early as eighteen months after the onset of syphilis. Syphilitic sarcocele commonly develops later. Otherwise, the ulceration of the scrotal wall, the fungoid growth, etc., all bear out the clinical picture of syphilitic sarcocele, sometimes associated with epididymitis. The second case, that of the patient with tubercular deposits in the lungs, bladder and prostate, Dr. Taylor said he considered a remarkable one, not only because of the general benefit derived from the climatic treatment, but also because of the improvement following the local applications of silver nitrate.

DR. F. TILDEN BROWN gave the history of a case of tuberculosis of the genito-urinary organs that came under his observation. The bladder was involved, and also, probably, the seminal vesicles and one kidney. Tubercle bacilli were found in myriads in the urine. The man was passing water every ten or fifteen minutes; it was red and turbid, resembling pea soup; moderate hæmaturia. Surgical interference was considered, but not undertaken, as nothing more than drainage could have been accomplished. The patient was sent to Saranac Lake and improved so rapidly that after fourteen months he obtained a position on a yacht. Very shortly after leaving Saranac, however, his vesical symptoms returned and rapidly led to a fatal issue.

DR. E. L. KEYES said he regarded silver nitrate as unreliable in cases of tuberculosis of the genito-urinary organs. In some cases it seems to do good, although he has never seen a cure effected by it. The climatic treatment is often very beneficial in these cases. In one case coming under his observation the vesical symptoms entirely abated during the patient's residence in Colorado. Sometimes long voyages seem to effect a cure.

DR. W. K. OTIS said, in regard to the climatic treatment of tuberculosis, that the tendency is not to continue it for a long enough period. A period of at least seven years is necessary in order to render the patient safe from recurrence.



DR. R. W. TAYLOR presented a tubercular testis removed from a man twenty-six years old. It was soft and pulpy to the feel and of a peculiar cinnamon color. This color was due, probably, to the extravasation of blood, and subsequent pigmentary changes. Dr. Taylor presented another specimen illustrating the occurrence of vaginalitis, which had gone on to such an extent that it involved the whole testicle, closing up the interspace between the parietal and visceral layers of the tunica vaginalis, and the hydrocele appearing as a bag above.

DR. T. H. MANLEY presented a specimen showing carcinoma of the glans penis, which was removed from a man sixty-seven years old. The man gave a history of having had vague pains in the penis for nearly a year before he came under observation. For six months there had been phimosis. This was relieved by splitting up the prepuce, when it was found that almost the entire left half of the glans had been destroyed by the malignant ulceration. Amputation of the glans was then performed. The glands in the left groin were enlarged and underwent acute suppurative changes. The man was a widower and for many years previous to the onset of the trouble had led a chaste life. Dr. Manley also presented a calculus removed from the bladder of a young man aged twenty-two years through a perineal incision. The calculus had an oxalate of lime coating, and a core consisting of carbonaceous substance. He also presented three small calculi removed from the urethra of a boy aged five years. They were found imbedded in the mucous membrane of the urethra, just anterior to the bulb, and were so situated that they acted as a sort of valve, completely closing the canal when pressure was brought to bear on them from behind forwards.

DR. J. R. HAYDEN presented a specimen of encysted hæmatocele of the cord, associated with hæmatocele of the tunica vaginalis. The patient gave a history of traumatism, dating back about ten years.

DR. MANLEY, in reply to a question, said that a histological examination had been made in the case of epithelioma reported by him, and had confirmed the diagnosis.

DR. ALEXANDER said in regard to the specimen presented by Dr. Manley, that of epithelioma of the penis, that it was in an unusual position, for the malignant process to begin. The ulceration, too, seems to have been unusually rapid. Suppuration of the glands in the inguinal region is not of common occurrence in epithelioma, and points more towards chancreoid ulceration.

DR. TAYLOR said that when cancerous infection of the inguinal glands occurs and suppuration takes place there is extensive involvement of the skin over the glands and we get a gaping wound which only ends with the life of the patient.

DR. E. FULLER referred to a case of epithelioma of the penis that he has had under observation for over six years. The process is extremely slow. The inguinal glands are very slightly involved.

DR. ALEXANDER showed a specimen of epithelioma of the penis. The process had gone on for two years and there was no involvement of the glands in the groin.

DR. MANLEY said that this was the first case in which he had seen the inguinal glands suppurate as the result of epitheliomatous infection. Up to the present time the wound in the groin has failed to heal. The man had long lived a chaste life and there was no suspicion of chancreoid.

Discussion of Dr. Klotz's paper, "On the Occurrence of Tertiary Lesions of Syphilis as the Result of Direct Local Infection, with General Remarks on Syphilis as an Infectious Disease."—JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, August, 1893.

DR. TAYLOR, in opening the discussion, carefully reviewed the conclusions drawn by Dr. Klotz in his paper. As regards the statement made by the author that syphilis is caused by a micro-organism similar to those of the acute exanthemata, Dr. Taylor said that our present knowledge on this point is only based on presumptive or analogical evidence. We do not know positively that the disease is caused by a micro-organism. Lustgarten and others, by various methods of staining, have found certain bacilli in syphilis; the results of these bacteriological investigations differ from each other, and the experiments have not been followed up by culture-growths or inoculation. They do not, therefore, come up to the requirements of Koch as to the identity of a given parasite.

The protoplasmic changes which take place in syphilis are the reproduction, *ad infinitum*, of the cells in the original lesion. That the general symptoms accompanying the disease and the impairment of nutrition are due to the toxins secreted by these cells, as stated in Dr. Klotz's paper, is a pure assumption. The remaining conclusions of the author, which are based on the theory that there is a primary micro-organism in syphilis, which under the influence of its own chemical products or of treatment, or in consequence of its natural innate character is eliminated or undergoes some modification or evolves a new kind of species of micro-organism, and that this secondary parasite produces the tertiary gummatous manifestations—all this must be regarded as pure conjecture. We are not in a position to-day to generalize upon the microbic action of syphilis. The data upon which the conclusions are based are not satisfactory; the cases are not conclusive. Clinical observation rather goes to show that the tertiary manifestations of syphilis are the result of a low grade of inflammatory process, that has been left over from the second stage. Because we observe tertiary lesions in patients from whom we can get no history of any previous specific manifestations does not necessarily imply that those lesions are the result of direct inoculation. The primary and secondary symptoms are often very slight. The syphilitic roseola may be so faint that it readily escaped detection. This is also true of the papular syphilide. The initial lesion of the disease may pass undiagnosed. It may be on the tonsil, giving rise to very little trouble, or it may be a small herpetic vesicle on the lip. The chancre may simply appear to be a slight excoriation of the mucous membrane.

In conclusion, Dr. Taylor said he had read the paper of Dr. Klotz with a great deal of interest. While he cannot agree with the conclusions laid down, still, these excursions into new fields of speculation are often productive of much good.

DR. C. W. ALLEN stated the assertion has been made that the bacilli of syphilis has been found in a few instances in gummatous lesion. If that is so, and we accept this bacillus as the etiological factor of the disease, it seems quite possible that infection may take place from such tertiary lesions. He understood that Dr. Klotz in his paper merely wished to give the idea of the possibility of such an occurrence taking place.

DR. KLOTZ, in closing the discussion, said that the conclusions reviewed by Dr. Taylor were simply the logical deductions of the hypothesis laid down

in his paper. They were not given as facts. In his paper he laid great stress on the fact that tertiary syphilis is so closely allied to tuberculosis of the skin. It is also important to note that in a large proportion of cases of tertiary syphilis (over 33 per cent.) you fail to get a satisfactory specific history. In conclusion, Dr. Klotz said that while he is well aware that he has not proven his case, still there are many points in support of the theory laid down.

**Aero-Urethroscopy, with Exhibition of New Instrument.**—DR. W. K. OTIS read a short paper on this subject, in which he reviewed the various instruments that have been devised for the purpose of inflating the urethra during urethroscopic examination. His own instrument for this purpose consists of a hard rubber disk, backed with metal, one and three-quarters inches in diameter, identical with the top of the Klotz tube. In the center of this disk is a circular aperture, half an inch in diameter, to the inferior edge of which is soldered a metal rim one-quarter of an inch deep, which serves as the male portion of a sliding joint, by means of which tubes of various sizes and lengths are attached. A glass diaphragm held in a metal collar and placed at an oblique angle to prevent the reflection of light is arranged on a pivot so as to swing over the aperture and hermetically close it, or, when desired, give ready access for the purpose of instrumental applications through the tube beneath by simply swinging in the opposite direction. A slight projection on the side of this cap locks under a metal shoulder riveted to the plate, the opposite side of which serves also as the shoulder by means of which the illuminator is fastened to the plate. A small metal tube extends from the edge of the plate into the movable cap; to the outer end is fastened a short length of rubber tubing with two India rubber bulbs, like those used in the Paquelin cautery, and by means of these the inflation is produced. Tubes of any desired length or calibre may be used with this instrument. To prevent the escape of air from the urethra, alongside the tube a metal cup (as is used in Antol and Fenwick's instruments) or a tube, the proximal end of which is cone-shaped (as is used by Henle) may be employed. If one is the possessor of a condensed air apparatus, the rubber bulbs may be advantageously dispensed with. The instrument weighs less than two ounces.

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## Book Reviews.

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*A System of Genito-Urinary Diseases, Syphilology and Dermatology.* By various authors. Edited by PRINCE A. MORROW, A.M., M.D., Clinical Professor of Genito-Urinary Diseases, formerly Lecturer on Dermatology in the University of the City of New York; Surgeon to Charity Hospital, etc. With illustrations. In three volumes. Vol. II. *Syphilology*. New York: D. Appleton & Co., 1893.

The editor states that in the preparation of this volume it has been the aim both of himself and of each collaborator to produce a complete and systematic treatise on each particular phase of syphilis and on chancreoid, that would be thoroughly up to date, and while embodying the most recent advances made in our knowledge of these diseases would still be essentially practical.

The initiatory section of the volume is on the history, geographical distribution, evolution, and general pathological anatomy of syphilis, and is written by Dr. James Nevins Hyde. In tracing the history of syphilis this author judiciously reviews the efforts that have been made to assign to it a prehistoric antiquity because of the supposed evidence afforded by certain bones exhumed in various countries; but the author observes that the early races of men would be subjected to influences that might determine in them osseous inflammation of exposed bones with results that resembled to-day those of other diseases, and pathological examination of these bones has sustained this surmise. We agree that the proofs of the existence of syphilis among the ancient Mexicans are as strong as any derived from a study of Egyptian papyri or Chaldaic inscriptions, but they are not one whit stronger.

A general rather than particular resumé both of the history and of the geographical distribution of this disease is given. The evolution, course and stages of syphilis are described, with no superfluous discussion of the unicity or duality of the chancreous virus. The reader is impressed with the fact that there is no line of demarcation between the successive phenomena of syphilis as they appear in the evolution of the disease in any given case, and that primary, secondary and tertiary may have been convenient clinical phrases but they did not describe an actual sequence of pathological entities. The author considers that the development of syphilis occurs in one of four principal directions: 1. Benignant syphilis, with mild and transitory symptoms. 2. Benignant syphilis, with relapsing or persistent superficial symptoms. 3. Malignant syphilis, with relapsing or persistent profound symptoms. 4. Malignant syphilis, with relapsing or persistent and profound lesions that are ultimately destructive. Necessarily there are innumerable variations clinically recognizable in each of these classes, and one may some time merge into another. Excellent reasons are given why the variation in type is dependent upon the soil, so to speak, in which the disease is implanted; in other words, upon the diathesis, stamina, or constitution of the person infected. Dr. Hyde strikes the keynote of the pathology of the disease when he states that the anatomico-pathological distinctions are best studied as variants of a normal histogenesis.

Dr. J. A. Fordyce is the author of the section on the ætiology of syphilis. He reviews the history of the various micro-organisms that have been described as the specific organism of syphilis, and while believing that analogy suggests its parasitic origin he leans to the opinion that it is more probably due to a protozoön than to a vegetable germ. He agrees with Hyde that the resisting power of the individual plays an important rôle in the evolution of the disease. The various sources and vehicles of the syphilitic contagion are mentioned and the author reviews the unsuccessful experiments made to inoculate syphilis in the lower animals.

The modes of infection in syphilis are described by Dr. L. Duncan Bulkley, and we learn that everything may be a possible source of infection. In fact, were one to live the life of a hermit he would still run the risk of coming in contact with something that had been infected by a syphilitic.

Dr. E. B. Bronson takes the opportunity in the chapter on primary syphilis to again advocate the theory that it is practically a local, or rather regional disease, rather than the local expression of a constitutional disease, as the patches on the throat of a diphtheritic patient are the indication of the



constitutional infection of diphtheria. This theory necessitates recourse to the idea of *dosage* (quantity of poison) being requisite to produce constitutional infection. This latter postulate does not seem to be a tenable position, because in all infectious diseases infection is dependent upon some inherent quality in the individual exposed rather than upon the length of time or any other factor associated with the exposure. While undoubtedly there must be an appreciable interval of time in which syphilis is a local disease it seems improbable that any therapeutic advantage can ever be taken of this.

The subject of constitutional syphilis is discussed by Dr. Joseph Zeisler, who calls attention to the fact that pathological changes occur in various organs and tissues of the body long before there is any external manifestation of the infective process. We have found that more important than the changes in the blood is the elevation of temperature almost always associated with the early stage of infection; in fact, in the negro, in whom mixed infection is by no means rare, the constitutional character of the lesion has been decided, and later events have corroborated the decision by an evening rise of temperature. The latter may be so great that it is ascribed to some other disease or so slight that it is overlooked by both physician and patient. It is the experience of many that the syphilitic cachexia is dependent upon the individual infected rather than upon insufficient, negligent or improper treatment.

The editor of the volume brings his large experience to the composition of the section on syphilis of the skin. He calls attention to the fact that no single feature of a dermatopathy is absolutely pathognomonic of syphilis, but the congeries of symptoms constitutes a clinical picture that is usually readily recognizable. He states that it is not the number and variety of the elementary lesions that give to this disease its protean physiognomy, but it is rather the ulterior changes that these lesions undergo that make up the bewildering diversity of the syphilodermata. We are inclined to question the importance of the rôle played by bacillary toxins in the production of tertiary accidents, because it does not seem that in that so-called stage the possible micro-organism exists in the body. The hetero-innocuousness of tertiary lesions substantiates this latter hypothesis. Such accidents would seem, in the light of our present knowledge of pathological and physiological processes, to be due to defective metabolism incident to degenerative processes that were primarily originated during the original constitutional infection, and not to specific organisms that were latent in the system. The author adopts the classification system of Cazenave, and describes with sufficient detail each of the principal eruptive forms.

Dr. S. Alexander is the author of the section on syphilitic affections of the hair and the nails. Syphilis of the mucous membranes of the mouth and tongue is described by Dr. C. W. Allen, who gives a very complete resumé of the various syphilitic manifestations of these regions.

Syphilis as it affects the joints, muscles, bursæ, tendons and aponeuroses is described by Dr. Frank Hartley in his usual thorough manner; but the reader is left completely in the dark regarding the best methods of treatment of these various manifestations.

Dr. W. R. Townsend commences the section on syphilitic affections of the bones with a description of gummata, which, while the most typical, are not the most familiar syphilitic osseous lesion. Periostitis and the sev-



eral varieties of osteitis are succinctly described, and his methods of treatment are essentially conservative.

Dr. John Noland Mackenzie premises the section on syphilis of the upper air passages, including the nose, pharynx, larynx, trachea and bronchi with a historical review of the evidence of the antiquity of syphilitic affections of these regions. His studies and experience have resulted in the curious conclusion that the existence of congenital syphilis seems often, other things being equal, to mitigate the severity of certain acute infectious diseases and to exert a favorable influence on their course. These conclusions are limited to scarlet fever, measles and chicken pox. Diphtheria seems to find an especially favorable ground for development and the child rapidly succumbs. His explanation of the reason for this mitigation is, that the poisons of the two diseases in their circulation in these regions appear to be mutually destructive, and the throat escapes by virtue of such reciprocal antagonism.

The subject of visceral syphilis is treated by Dr. W. F. Councilman, who takes the position that the later visceral lesions are due to a toxalbumin. That the ætiology of earlier and of later lesions is not, in every respect the same is evidenced by the facts that mercury is the true remedy for the former and iodide of potassium for the latter. Dr. Councilman does not believe that syphilitic lesions of the lungs are extremely rare, though these lesions do not take the form of a destruction of lung tissue with cavity formation; the latter condition has often been reported as of syphilitic origin, but it is usually tuberculous. Both the pancreas and the suprarenal capsules he has found to be comparatively immune from syphilitic lesions.

Dr. J. B. Tuttle is the author of the section on syphilitic affections of the rectum and anus, and he states that the course of the disease in those regions varies from that pursued elsewhere in the body only so far as it is influenced by the anatomy and functions of the part.

Dr. Eugene Fuller has contributed a very useful section on syphilis of the male and female genito-urinary system.

The section on syphilis of the nervous system is by Dr. B. Sachs, who considers that this form of the disease is steadily increasing, not because there is a general increase in syphilis, but because it is more frequently associated with those potent inciting causes of nervous disease—excessive work, worry and the alcoholic habit. Dr. Sachs makes a startling statement, that syphilis of the nervous system appears not infrequently after soft chancre without the customary secondary eruptions. There are no customary secondary eruptions after soft chancre, though hard chancre is not invariably followed by an eruption. If the initial lesion is indubitably a chancreoid then it would seem that some other pathological process than that of syphilis must be the cause of the neurosis. We think that Dr. Sachs' own statement refutes his proposition that this phase of syphilis is due to improper treatment during the initial period, as he says the intensity of the infection is an individual phenomenon but slightly related to therapeutic measures. Four methods are given whereby the syphilitic origin of nervous diseases may be diagnosticated, though the author states, regarding each of them, that it is not an invariable diagnostic indication. The author strongly inclines to the opinion that syphilis exercises a preponderating influence in the ætiology of tabes.

The entire section exhibits the characteristic thoroughness of the author's work.

Dr. W. N. Bullard is the author of the section on hereditary syphilis of the nervous system; Dr. C. S. Bull of that on syphilis of the eye and its appendages, and Dr. J. Orne Green of that on syphilis of the ear. The name of each of these authors is sufficient guarantee of the character of the work.

One of the best expositions of our knowledge of the subject of hereditary syphilis is the section by Dr. F. R. Sturgis.

It is to be hoped that every reader of the volume will be impressed by and will follow Dr. H. G. Klotz's advice in the section on the diagnosis and prognosis of syphilis, to refrain from instituting specific medication until all those symptoms are present that, according to generally acknowledged principles of pathology, are not observed in any other disease but syphilis. This author emphasizes the difficulties of diagnosis and he enters elaborately into the various factors relating to diagnosis and prognosis.

Dr. J. William White states, in the section on the treatment of syphilis, that the essential point is the administration, during a sufficiently long period, of the largest dose of mercury that can be taken and absorbed without prejudice to the general health. Dr. White prefers inunction for the administration of mercury, though he considers at length the various methods employed in administering this remedy. The treatment of the later manifestations of the disease by the iodides, and the local treatment of the chancre and the syphilides are well considered.

Dr. S. T. Armstrong is the author of the section on syphilis in relation to public health, and he concludes that the importance of this disease as an insidious factor has been somewhat overrated, though the fact that it is a disease most often transmitted by mediate contagion would indicate the possibility of preventive measures for its control. Those that have been adopted seem to have failed in attaining their purpose, and this author urges that all general hospitals receive syphilitics applying for treatment and seek to retain them until the period of infecting danger is over.

Dr. Edward Martin is the author of the section on the chancre, that he justly considers is caused by a specific microbe. We are very glad to note that this author believes that too much dependence is placed on the induration of a venereal sore as a means of distinguishing a hard from a soft chancre; for in the latter there may be an inflammatory induration that will make it impossible for the physician to say positively what is the true nature of the lesion.

Dr. J. P. Tuttle is the author of the final section, on chancre of the anus and rectum, in which he gives an excellent resumé of this subject.

One cannot but be impressed by the wide scholarship that is shown by the authors of the various sections, and each has endeavored to present the latest information regarding the topic about which he writes. The literature of all nations has paid tribute to the composition of this volume, that is an admirable exponent of our present knowledge of syphilology. The work is handsomely illustrated and every care has been given to make it a *magnum opus*.  
S. T. A.

*A Dictionary of Medical Science*; containing a full explanation of the various subjects and terms of anatomy, physiology, medical chemistry, pharmacy, pharmacology, therapeutics, medicine, hygiene, dietetics,

pathology, bacteriology, surgery, ophthalmology, otology, laryngology, dermatology, gynecology, obstetrics, pediatrics, medical jurisprudence, dentistry, etc., by ROBLEY DUNGLISON, M.D., LL.D., late Professor of Institutes of Medicine and Medical Jurisprudence in the Jefferson Medical College of Philadelphia, etc. Twenty-first edition, thoroughly revised and greatly enlarged, with the pronunciation, accentuation, and derivation of the terms, by Richard J. Dunglison, A.M., M.D. Philadelphia : Lea Brothers & Co., 1893.

It was the purpose of the learned author of this dictionary, as announced in its first edition, "to make the work not a mere lexicon of terms, but to afford under each a condensed view of the various medical relations, and thus to render the work an epitome of the existing conditions of medical science." A scope so encyclopædic in character as this implied far less sixty years ago, ambitious as it was then, than it does to-day. The rapid progress in medical science which has marked the latter half of the century, accelerated by division of labor in the different departments of medicine, together with the enormous product of new matter and new terms, have almost entirely transformed the field which the lexicographer has to survey, and have extended it immensely. For one man to epitomize the vast body of material in accordance with the above comprehensive plan must be a Herculean task, and yet this is the task which the present editor of Dunglison's Dictionary undertook. We were therefore curious to see how the purpose had been carried out with reference to that small department of the field which especially concerns this journal, to see how the "existing conditions" in dermatology and syphilis were represented.

When Dunglison's Dictionary first appeared, the dermatology taught and accepted was something very different from what is comprehended under that subject to-day. It was mainly the dermatology of Willan and Bateman. Since then radical changes have been made. Much that was then current has long been relegated to oblivion or to the "obsolete," and terms and diseases not then dreamed of have become trite subjects of discussion in medical journals and meetings. The progress of events has by no means been ignored in the work before us, but, speaking only for the departments in which we are especially interested, the improvement upon the older editions has not been what we might reasonably expect. In short, the matter is not "up to date." In too many instances where new definitions or new terms are introduced it is in such a way as to jostle old ones still retained, while cross references are often so misleading that the effect is confusion. The old Dunglison had an antiquarian interest of its own, but the fresh matter here introduced is oftentimes so ill assimilated as to produce something like the effect of putting new wine in old bottles. A few illustrations will serve to make our meaning more clear.

It is a well-known fact that Willan used the old Greek word *lepra* for psoriasis. The same term, however, was used by early translators of Arabic writers into the Greek for leprosy, and this use of the term is the one generally adopted at the present day. "Leprosy" as a separate heading is given a succinct and correct definition, but under "Lepra" there is a long article in which there are described three forms, two of which, though very vague, are more or less distinctly leprosy, while the third "includes all the varieties met with at the present day," "is characterized by scaly patches," and is clearly the lepra of Willan—psoriasis.

"Psoriasis" is defined as "a cutaneous affection consisting of patches of rough amorphous scales, continuous or of indeterminate outline; skin often chappy." "The surface under the scales is more tender and irritable than in lepra" [What lepra?], "which psoriasis in some respects resembles." Presumably this is the "psoriasis" of Willan, which was nothing more nor less than a scaly form of eczema.

A similar confusion exists with regard to elephantiasis. "True leprosy" (under Leprosy) is defined as "Elephantiasis Græcorum," but on looking for the latter term we find "Spedalsked, of Norway—probably the same disease as lepra." [What lepra?] "See Lepra." "Elephantiasis Arabum" is followed by these words—"The tubercles are chiefly on the face and joints. There is loss of hair except on the scalp: voice hoarse and nasal, the disease is said to be contagious and hereditary." If this is not leprosy what is it? Then follows a more or less clear description of what is generally known as elephantiasis of the Arabs ending with "See Lepra."

The student who "looks up" "eczema" in this dictionary will acquire scant information of the disease as commonly understood at the present day. First he will receive the misinformation that it is pronounced *ecze'ma*. The definition is "Heat eruption. Eruption of small vesicles on various parts of the skin, usually set close or crowded together, with little or no (*sic*) inflammation surrounding their bases, and unattended with fever." "Eczema rubrum" is "an inflammatory form of eczema"; "eczema impetiginosum" is "eczema produced by irritation of sugar or lime"; "eczema mad-dans" is "eczema rubrum," eczema suborrhoicum, about which so much has been written in the last few years, is not in.

For scabies the now almost obsolete term "psora" is retained, under which the disease is defined as "connected with an insect, etc."

"Gutta rosea" or "acne roseacea" is defined as necessarily a pustular disease. "Rosacea" does not appear. "Acne varioliformis" is a "pustular form attended with eruption like small-pox; molluscum contagiosum." This is Bazin's use of the term. The disease which Kaposi designates by the same term and which is the only disease understood by it now is nowhere mentioned.

"Chloasma" is defined as a parasitic disease (*pityriasis versicolor?*), and we are informed that "sulphur internally—in any and every form—generally removes it speedily," while underneath come "C.gravidarum," "C.hepaticum," "C.toxicum" and "C.traumaticum." "Chromophytosis" appears and with this definition: "In this country synonymous with *tinea versicolor*; in continental Europe with *pityriasis versicolor*." Looking for "*pityriasis versicolor*" we find it defined—"tinea versicolor."

"Phtheiri-asis" is defined as "a disease which consists in the excessive multiplication of lice, *pediculi tabescentium* on the human body, under conditions in which it does not ordinarily take place, and in spite of cleanliness." *Pediculi tabescentium* "are said to differ from the common louse." This belongs to the time of Plenck.

Under "Rubella" R $\ddot{u}$ theln is defined, but neither this word nor *rubeola* are given as equivalent terms. We are told the disease is "not contagious."

"Xanthoma," "vitiligoïdea" and "xanthelasma palpebrarum" have each a separate definition, as though they were different diseases. The last named is said to be "a condition like *vitiligoïdea favosa*" [whatever that



may be; no such term appears under *vitiligoidea*], while *xanthoma* is followed by "*xanthopathia*" as an equivalent term. The latter is defined as "yellow coloration of the skin produced by pigmentary change; including *lentigo* and *chloasma*." *Chloasma* was defined as a parasitic disease.

*Xeroderma pigmentosum* does not appear. We find "*Kaposi's Disease*," which refers to "*atrophoderma pigmentosum*, parchment skin." *Atrophoderma pigmentosum* has no separate heading. Parchment skin appears and is defined. Such instances of confusing cross references are not infrequent. "*Albinismus*," "*albinoism*" and "*albitudo*" all refer to "*albinism*," and referring to albinism we find simply "See Albino and Albinism." "*Abscessus mammae*" refers for definition to "*mastodynia apostematosa*," but one searches in vain for *mastodynia apostematosa* elsewhere.

"*Syphilis*" is "an infectious disease communicable by coition or by contact of parts that are only lined with a thin epidermis, as the lips, nipple, etc." It would seem as though some improvement upon this antiquated definition of the older editions might have been essayed. "*Primary syphilis*" "includes the incubating period from the time of infection to the appearance of the initial lesion," [?] and we are informed that "*tertiary syphilis* does not occur frequently at the present day on account of the successful treatment of the first and second stages."

These few examples taken at random suffice to illustrate the defects of the work and to show that as an "epitome of the existing condition" of dermatology at least it does not meet what should be reasonable requirements of a medical dictionary of the present time. E. B. B.

*Lehrbuch der Urethroscopie.* (*Text-book of Urethroscopy.*) VOX. DR. F. M. OBERLAENDER. Mit 9 bunten Tafeln und 21 Abbildungen im Texte. Verlag von Georg Thieme, Leipzig, 1893.

Twelve years have elapsed since the publication of Grünfeld's Treatise on Endoscopy, during which period it has remained the standard, if not the only work on the subject. Not that the urethroscopy had not been taken up practically by many physicians who readily appreciated its great advantages; but the work was so thorough, and Grünfeld was considered such an authority in this line, that only a man with a large experience could undertake to write a new treatise.

No doubt, nobody was more qualified for that purpose than Oberlaender, who is favorably known as a prolific writer on genito-urinary surgery, and who is considered the most enthusiastic advocate of endoscopy. According to him, no case of chronic gonorrhœa can be regarded as cured, even after the cessation of any discharge, unless an endoscopic examination reveals a normal condition of the mucous membrane of the urethra, a demand which, in our opinion, very often remains a *pium desiderium*.

After examining the treatise before us, we gladly admit the eminent fitness of the author for the task "to give the views and the observations, which have met with general approval, and which are shared by my pupils."

The book—in the preparation of which Dr. Kollmann, Privatdocent of Leipzig, has taken part—is divided into fourteen chapters, the first four being devoted to a description of the instruments and their use. As to the former, the author maintains that the examination of the urethra with reflected light is not sufficient to reveal "the pathological details which are necessary for diag-

nosis and treatment." His electro-urethroscope illuminates a given part of the urethra directly, the light being located in the distal end of the endoscope. Oberlaender considers this instrument the *conditio sine qua non* for a successful endoscopic examination. We have never employed it ourselves, and do not know how much superior it is to Leiter's or Otis's endoscopes; but we do know from an extensive use of the latter, that they are perfectly satisfactory, and we doubt very much if Oberlaender's rather cumbersome instrument will ever become popular, at least in this country. In speaking of the new instrument of Otis, which Oberlaender thinks "has no special novel advantages," he incorrectly attributes it to Fessenden-Otis instead of his son, W. K. Otis.

The general rules the author gives concerning the ocular examination of the urethra contain a great deal of valuable advice. The description of the endoscopic pictures of the normal urethra, based upon the examination of "many thousands of different urethras," is clearly set forth. We approve of the suggestion to employ tubes of large caliber, but must take exception to the author's remark that the bloody dilatation of the meatus is "superfluous and in many cases unjustifiable."

As to the pathological conditions of the urethra, as seen through the endoscope, Oberlaender endeavors to classify them upon pathological-histological changes which he describes in three chapters, viz.: pathological changes in the epithelial layer, glands and the mucous membrane; the latter especially in chronic gonorrhœa.

The histological studies which the author has made in conjunction with Professor Neelsen, of Dresden, and the results of which have been given in detail in their treatise on the pathology and therapy of chronic gonorrhœa, are certainly very interesting, but they do not seem to deserve the practical importance which the author claims for them. The post-mortem condition naturally differs materially from the one in the living subject, so that binding conclusions can be hardly made from the one to the other. No doubt the author considered a description of the histological researches necessary to clearly set forth the different endoscopic conditions; but in a book devoted to "practical endoscopy," this part of the subject ought to have taken up less space.

Time forbids us from going into a detailed analysis of the endoscopy of the different forms of the urethral inflammations which the author describes in seven chapters, four of which are devoted to the various forms of infiltrations of the walls of the urethra, one to the endoscopy in affections of the posterior urethra, and also one on urethral tumors. A short chapter on endoscopy of the female urethra concludes the work.

Nine excellently executed chromolithographic plates illustrate the various endoscopic conditions. The publisher's share of the work has been well done.

In concluding this review, we suggest that a little more space might have been devoted to the clinical side of urethroscopy. A chapter on endoscopic treatment would not have been out of place.

H. G.

*A Handbook of Local Therapeutics.* By Drs. ALLEN, HARTE, VAN HARTLINGEN AND HARLAN. P. Blakiston, Son & Co., Phila., 1893.

It is quite a clever and "catching" idea, this of issuing a book on local therapeutics. The work before us is a composite one. General surgery is

represented by Dr. Harte, while Dr. Van Harlingen looks after the skin, Dr. Allen cares for the ear and throat, and Dr. Harlan sees that the eye is not neglected. The various drugs are placed alphabetically; their medical and common names are stated, and their pharmaceutical properties most often taken from the U. S. Pharmacopæia or Dispensatory, are given. Then follows, under the separate divisions of surgery, diseases of the skin, diseases of the ear, throat and nose and diseases of the eye, an account of its local therapeutical uses.

We are now interested in the book as a contribution to dermatological literature. Unfortunately "dermatology" suggests "local therapeutics" to most minds rather than general treatment. In the book now before us a goodly array of remedies, including many of the most recent ones, is presented to us. The author is so well and favorably known that it goes without saying that what he has given us is well worth reading, and is very helpful. We can but wish that he had given us more. We regret to say that in looking over the book we note that neither Marsden's nor Bougard's paste is given; hair dyes and depilatories are wanting entirely; but few of the oleates receive mention; and mercurial plaster is commended only for syphilitic nodes and glandular enlargements. The make-up of the book is good. The types are so distributed as to enable the reader to see at a glance the name of the drug, the division of the subject, and the list of diseases. A good index both of drugs and diseases is furnished. The editor has placed all references in the text and not at the bottom of the pages. We wish that authors would give their references to medical journals by the year, volume and page. Such a reference as "Semaine Med., 1891, No. 27," for instance, is a sin against busy men. If the page were given the time lost in looking over a whole number or referring to the index of the volume would be saved.

G. T. J.

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## Items.

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**Exchanges.**—The publishers of the journals with which we exchange will greatly oblige us by addressing all journals intended for the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES to it by title, in care of D. Appleton & Co., as many exchanges addressed to the firm alone fail to reach the editor.

**Euophen-Aristol as a Dressing in Cancer.**—Dr. S. P. Heilman of Heilman Dale, Pa., writes as follows concerning these agents: On the 28th of May, 1892, Mrs. L., aged 64, came under my treatment for cancer of the right breast, of which trouble she herself first became cognizant in February of the same year. At this time, namely, May 28th, nearly the whole of the breast was affected, presenting a hard tumor of the size of a man's fist, and the glands in the near axilla hard and indurated; no open sore was, however, present. I placed her on a alterative treatment internally and dressed the indurated breast with ichthyol and lanoline. One month later, June 27th, I had the whole cancerous mass cut away, including all the near axilla. Under the usual antiseptic dressings the edges of the incised tissue healed kindly together, and with reasonable promptness except the end of the incision towards the sternum, but with repeated applications of

aristol this part also united. She was given internally Fowler's solution, chian turpentine and iodide of iron.

Six weeks after the operation indications were already at hand of a likely recurrence of malignant action at the original place, and in three months after the operation a crop of nodules of the size of a pea, and larger, had formed along the line of incision made in June. These nodules later became soft on the surface, the soft surfaces in turn became suppurating surfaces. These surfaces were freely dressed with euophen aristol, the combined product prepared by the Farbenfabriken Vorm. Friedr. Bayer & Co. The iodizing, antiseptic, cicatrisant action of the euophen-aristol had a prompt effect in arresting further suppurative action, producing dry scabs, which in turn fell away, and left an apparently healthy and certainly a clean surface from where the scabs had fallen.

So satisfactory was this action of the euophen-aristol that after a very brief use of it all the disagreeable odor of the suppurating nodules had entirely disappeared, and did not again reappear, and strong hopes were entertained that the malignant action had been arrested.

But this hope was not tenable, as crop after crop of nodules appeared, again and again seemingly to be conquered by the euophen-aristol. At this stage, about November 20th, the external use of the euophen-aristol was aided by the internal use of methylene blue, two grains, in capsules three times a day. Again a most favorable showing in the woman's favor was evident, both as to her general condition, bringing about an improved appetite, a feeling of buoyancy of the most marked kind, and locally, healthy action of the most promising character. The use of the methylene blue was continued uninterruptedly during the Winter months, as well as the euophen-aristol externally, under which latter the patient declared that she could keep herself in a very comfortable condition, as it had relieved her of the darting pains which had appeared before the use of this dressing, and which pains are so characteristic of malignant, especially of cancerous action. It enabled her also to keep herself in a clean, odorless and tidy condition. This effect of the euophen-aristol alone recommended it as of almost incomparable utility.

About the middle of May, nearly a year after the operation of excision, a new crop of nodules developed at the same place as the former ones, but much more active in proliferation, and in enlarged sizes, accompanied with considerable pain, and daily, free, surface hemorrhage. Nothing was found, applied externally, to control the pain and especially to promptly stop the bleedings nearly as well as the euophen-aristol. The internal use of methylene blue was stopped and bromide of arsenic substituted.

At this writing, September 20, 1893, nearly a year and three months after the operation, and one year after recurrence, the woman is in fairly good health, doing all her housework, sleeping and eating well, but with a showing at the breast of a not very promising character. In all this time experiments with various kinds of dressings were resorted to, alumnol dermatol, etc., always to return to the euophen-aristol as furnishing the cleanest, the most acceptable, the most thorough antiseptic and cicatrisant dressing, and furthermore as having a more decided retarding and mollifying action on the progress of the apparently uncontrollable malignancy.



# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

### THE REQUISITES OF A SUSPENSORY BANDAGE, INCLUDING REMARKS ON ITS USES AND ABUSES<sup>1</sup>

BY

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New York.

ONE cannot practice genito-urinary surgery without having his attention strongly drawn to the fact that in very many instances suspensory bandages as ordinarily worn fail in great measure to accomplish their purpose, which is that of supporting and holding the testicles, or perhaps more properly the scrotal contents. Such failures may be due to faulty construction of the bandage or to an attempt to adapt a bandage, which may of itself be correct, to a figure for which its pattern is not suited. In this article an effort will be made to point out the defects of the apparatus as it is commonly manufactured, and to enable the practitioner not only to give his patient proper advice regarding the pattern to be procured, but also to correct any errors that may exist after it has been procured.

Figure No. 1 represents in a general way the front view of an individual wearing the pattern of bandage most commonly seen. In the drawing this bandage is in position and is serving its pur-

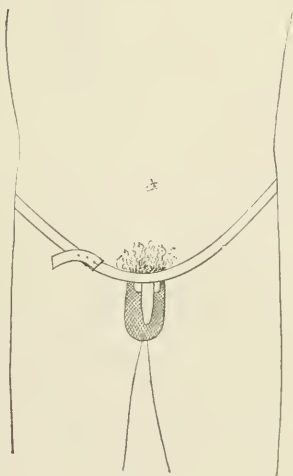


FIG. 1.

<sup>1</sup> Read at the December, 1893, meeting of the Genito-Urinary Section of the New York Academy of Medicine.

pose very well. With such a suspensory the band which goes about the body and from which the bag is directly attached, should be firm and unyielding and not flimsy and elastic, as is so often the case, allowing in such instances the scrotum, especially if it be at all heavy, to drag freely. Rarely one sees bands of this pattern made of firm elastic which are effective if very little support is required of them, and perhaps a trifle more comfortable, owing to their limited elastic qualities, but still such makes are commonly to be discouraged since the elastic strands rot so readily that in many instances before the suspensory leaves the hands of the retail dealer its usefulness is by this fact largely impaired.

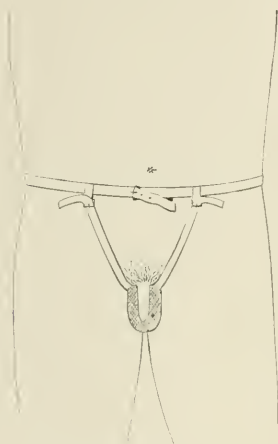


FIG. 2 (Front).

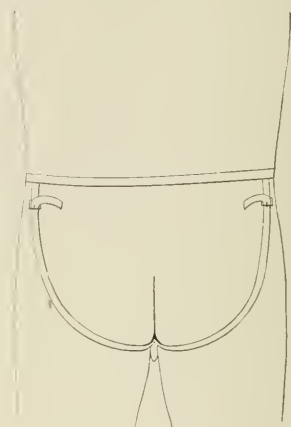


FIG. 2 (Back).

The patterns, also, of the bags vary greatly, and should be carefully considered. In one extreme they are so deep and roomy that although the scrotal contents are confined they are still allowed to drag, and in the other they are so shallow that although the scrotal contents are supported, yet they are not confined, but are in constant danger of slipping out, generally at the sides and occasionally behind in case the back straps are not kept taut. If a suspensory is faulty in the first of these particulars it is easy to remedy it by taking up the slack, best by means of a needle and thread, but oftentimes for practical purposes with safety pins. If, however, the bag is too shallow there is nothing to do but to condemn the whole bandage. Most suspensories of this pattern require back straps, though

in some instances where there is an absence of inflammatory conditions, and where only a moderate amount of support is required, the back straps may be dispensed with, provided the bag is quite deep. The function of the back straps in this form of suspensory is not only to prevent the scrotal contents from slipping out, but also to steady the parts suspended, limiting their mobility, and consequently guarding them in large measure against vibrations. The actual support rendered by the straps in these instances is very small. It therefore follows that there is no need of great strength or firmness in them, rather light elastic material serving the purpose.

Fig. No. 2 (front and back view) represents a suspensory bandage far more serviceable than the one just considered in cases where firm and secure support for the scrotal contents is required. Here the source of support is a firm waistband which is buckled securely above the hips. From this support by means of two front and two back straps the bag is suspended. The length of the front and back straps can be carefully regulated by buckles at the waist. These straps should be of firm material. The front straps, of course, bear a large per cent. of the support; still, considerable of this function devolves on the back straps, as well as that of steadying the scrotum and preventing it from slipping out, consequently they are of more importance than in Fig. No. 1, and should be much stronger. Where the scrotal contents is heavy they should be made non-elastic, like the front straps, and just as strong. In some cases, however, where the support required is not great they may have a limited amount of elasticity, though they should always be much stronger than the back straps in the first pattern.

Diday, *Lyon Médical*, Sept. 3d, 1893, advocates a suspensory made on this pattern. Instead of employing buckles, however, buttonholes are made in both the front and back straps, and buttons are sewed to the waistband. Such an arrangement would necessitate careful preliminary measurements in each instance so as to get the buttonholes in the right place, every bandage, in other words, requiring to be made to order, whereas with buckles a ready-

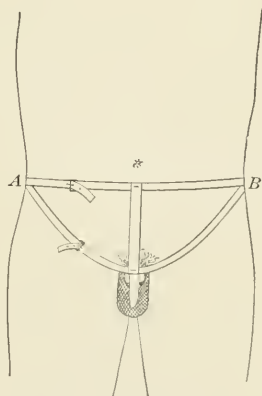


FIG. 3.

made apparatus can be easily fitted and subsequently adjusted in case the straps stretch. In these bandages also the bag can be unfastened from the straps, cleansed and replaced. The W. F. Ford Surgical Instrument Co., of this city, make these bandages, modified somewhat from the French pattern, according to suggestions offered by me.

Oftentimes when unable immediately to obtain a Fig. No. 2 suspensory, I have been able to rig a suitable temporary contrivance, as represented by Fig. 3. Here the ordinary Fig. No. 1 suspensory has been obtained. A firm waistband has been

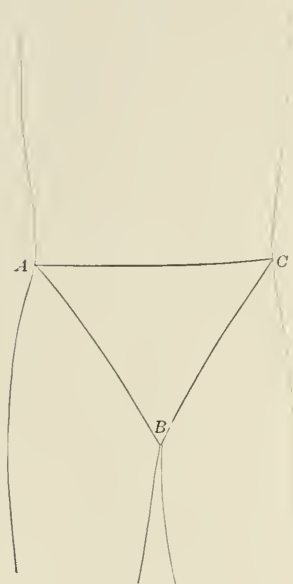


FIG. A.

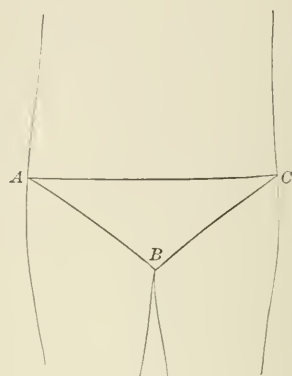


FIG. B.

adjusted and fastened laterally at A and B to the body band of the suspensory. Then a firm band, C, has been fastened in the middle line above to the waist band and below to the suspensory band just above the pubes.

As has been mentioned, the contour of the patient also should be considered in selecting a suitable suspensory bandage. If an individual is tall and slender Fig. No. 1 is liable to render much better service than in cases where the patient is short and stout. This is for two reasons. In the first place, in a slender individual, the hips are more prominent and the waist is smaller in comparison. The body band therefore has a



secure purchase and is not in danger of slipping. Secondly, the angle of support, A B C, of the waistband, as seen in the diagrams, is more acute and consequently much more effective in Fig. A, representing a tall, thin person, than in Fig. B, representing a short, stout person. In a short, stout person, therefore, and in all cases where considerable support is required, a Fig. No. 2 suspensory is the pattern best adapted.

An individual requiring scrotal support may be so stout that the waist measurement exceeds that of the hips. In the case of such an individual a Fig. No. 1 is of course of no use. A modification of Fig. No. 2 may, however, be of service. Such a suspensory should be fitted. The waistband, however, should be wide and of considerable consistency, otherwise it will be liable to become wrinkled and to cut into the soft abdominal fat. Then suspender buttons should be sewed to the belt, and an ordinary, somewhat elastic, pair of suspenders adjusted. Such an arrangement generally serves its purpose well in these usually troublesome cases.

In cases where it is necessary for the patient to remain in bed with his testicles supported, as is frequently required in active inflammatory conditions, such as acute epididymitis, the forms of support which we have already considered, and which apply to walking cases, are not suitable, and another device is called for. In these inflammatory cases the patient should lie flat on his back. His testicles should not be allowed to hang at all, but should be drawn up and placed on the pubic bone, and allowed to remain there. Figure No. 4 represents the required form of support in such instances. This support can be adjusted at the bed side, firm muslin and safety pins alone being required. A broad waistband is first firmly applied and then to this a broad sling is pinned which includes the testicles, holding them in their suprapubic position. The penis naturally lies upward on the hypogastrium, as seen in the diagram. To prevent this sling from slipping up, back straps, which cannot be represented in the drawing, are adjusted, and to guard against the testicles slipping over the rim of the loop, in case the patient is restless, a strip of muslin is pinned across, as seen

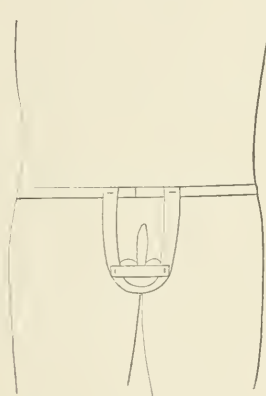


FIG. 4 (Reclining).

in the figure. Oftentimes, however, in these cases the inflamed parts are so tender that they cannot be brought directly in contact with any support, as represented in the figure, but require to be done up in poultices, fomentations, cotton, wool, etc., as the case may be. Still, no matter in what substances they may be enveloped, the position of the testicles resting on the pubes should be maintained, and such can readily be done by the apparatus just described, only in these latter instances the loop fastened to the waistband should be made extensive enough to include the scrotal wrappings. In some instances, where not only support for the testicles, but also compression is required, the ordinary roller bandage may be employed. E. Wickham, of Paris (*La France Médicale*, February 3d, 1893), advocates such a procedure. In these cases before applying the bandage, cotton, or, what is far better, lamb's wool, is packed about the scrotum. After several rather unsuccessful attempts to neatly adjust such an appliance as represented by Wickham, a single roller being employed, the idea occurred to me to use a double roller and to imitate the well-known procedure employed in bandaging the head with the double bandage. By so doing one end of the roller made continuous circular turns about the waist while the other made backward and forward turns from over the pubes to either side of the sacral region and back again. each loop of the transverse bandage encircling and being held by the corresponding circular turn of the other end of the bandage. By these means the entire scrotum, wrapped in its wool envelope, can be neatly and very effectively secured, a slight elliptical space being left in front through which the penis projects. Behind the backward turns of the bandage deviate to either side, thus leaving the rectal region free. This bandage is especially serviceable in inflammatory cases where it is not practicable for the surgeon to insist on rest in bed.

This part of the article would not be complete without mention being made of the "Jockey Strap," which oftentimes serves as an efficient suspensory bandage, besides performing, as it were, the functions of a splint to the penis in some very inflammatory conditions of that organ where it is necessary to have it held up against the abdomen, pledgets of cotton being placed at either side to prevent it from slipping laterally.

The suspensory bandage is an appliance in very common and general use. Oftentimes at the first consultation for some trouble connected with the genito-urinary organs, the surgeon finds that his patient has already supplied himself with this

article of his own volition, or at the suggestion of some friend. When asked why this was done various answers, generally vague and indefinite, are received. All this, however, goes to show that the suspensory bandage has won for itself a firm place in the popular estimation. Inflammatory conditions of the epididymis and cord, the result of the extension of a pre-existing inflammation of the deep urethra, or the fear of such an extension of a urethral inflammation, are causes which account for the use of this apparatus in the great majority of instances. In many cases also, where surgical treatment is required in connection with the deep urethra by means of sounds, injections, applications, etc., or where the deep urethra has to be disturbed in making vesical explorations or catheterizations it is oftentimes well to prescribe a suspensory to be worn during the initial stages of the treatment, or until the tolerance of the parts is well established. For nothing is more disappointing to the surgeon in such cases than a forced delay in local treatment, owing to a supervening acute epididymitis. It will thus be seen in this important group of cases which have just been considered that the suspensory bandage is prescribed not only to modify an existing inflammation in the parts to be supported, but also as a prophylaxis against inflammatory invasion. In what proportion of these cases trouble is averted by the early application of support to the parts I am not prepared to state, as I do not know, although I am convinced, and I think all workers in this department concur with me, that the percentage is considerable. In case urethral inflammation extends from the deep urethra along the cord and into the epididymis the popular professional attention is directed solely to the epididymis, the condition of the cord and the corresponding seminal vesicle being ignored, and if one asks why a suspensory is applied he will be told that it is to modify the trouble in the testicle or epididymis. This is probably because, in the great majority of cases, the acute tenderness and most of the pain is centered in or appears to radiate from the epididymis. The function, however, of the suspensory bandage which, by reason of holding up the testicles, takes all tension and strain off the cord, is very important and should always be carefully considered in case the surgeon expects to attain any degree of success in the treatment of these cases. In order to appreciate this function of the suspensory in taking tension off an inflamed cord, it is well to study numerous cases where, during the acute attack, and afterwards, either no or inefficient support

was rendered the testicle. In such cases oftentimes the epididymis seems to have recovered largely as far as pain and tenderness are concerned, although it is usually more indurated than it should be were the case carefully treated. It is, consequently, satisfactory to an easy-going patient, though not so to the surgeon, since the more dense the induration the less chance there is for spermatozoa ever getting their right of way through that region. When, however, one comes to examine the cord in these cases he is apt to find it not as it ought to be, about the size of a heavy leather shoestring, but enlarged, usually to the size of the little finger and frequently to that of the forefinger, quite hard and somewhat tender on pinching. In some of these cases, and especially those where the cord is most enlarged complaint is made of tenderness and shooting nerve pains radiating from the corresponding inguinal region. This is due to the fact that the cord, owing to its increase in size, squeezes the accompanying nerves in the narrow confines of the inguinal canal. If much exertion is taken under these conditions tenderness and pain re-occur in the epididymis. Although this condition of the cord is commonly seen in cases where the testicular support has been faulty, still it will not do to infer every time one sees a badly swollen cord that the support in this case has been inefficient, as there exists a class of cases, not very common, to be sure, mention of which was made in my article on "Seminal Vesiculitis" (*JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES*, September, 1893), where inflammation, very acute in character, confines itself largely or wholly to the seminal vesicle or to the vesicle and the cord, the epididymis escaping. In such an instance the cord may swell very much in spite of rest and the most careful support. Such a condition is an exception, however, and the general rule holds that where one sees a markedly tumefied cord persisting after resolution in the epididymis has been fairly established the inference that the testicle has not been properly supported is allowable.

One often sees statements, good authority being quoted, of the very rapid cure of acute epididymitis by means of applications with the Paquelin cauterizer by aspiration or incision into the tunica vaginalis or by numerous lotions, ointments, poultices, etc. Such statements are very misleading and inaccurate, since the word cure is used in the place of the word relief. By these and various other measures which may be applicable to certain cases speedy relief from very agonizing pain may be experienced and a patient may be thereby very firmly con-



vinced that he is cured, although that, it seems to me, is no reason why the surgeon should take the same optimistic view.

These measures for prompt relief of pain should, of course, be used in conjunction with the support of the parts, and the parts should continue to be supported for a long time after the acute symptoms which manifest themselves by pain and discomfort have subsided; in fact, until all induration of the cord and all save the permanent induration of the epididymis have disappeared. By reason of this apparently rather common misapprehension some practitioners strive to cure their cases omitting the element of support, and others, who have not had much experience, are liable to think that the surgeon who does not claim to speedily cure these cases cannot be very clever. In acute cases of epididymitis, especially if the cord is much involved, rest in bed with the form of support represented in Fig. 4 is desirable till the active engorgement of the parts has subsided. This is advisable, not only because the position of the testicles on the pubes as attained by this support represents the most complete rest together with the minimum tension on the cord, but also because in this position the blood tension in the parts affected is largely reduced. This latter consideration in these conditions is an important one, and though it hardly falls within the scope of this article, still I trust that a brief allusion to it will be allowable. Within the last few years the attention of the medical profession has been drawn to the consideration of this question of blood tension in this region by those making a special study of rectal diseases. It has been shown by these investigators that many chronic inflammatory and engorged conditions of the rectum which had formerly seemed to be well nigh incurable get well simply by rest in bed associated with elevation of the hips, exactly as does oftentimes a chronic ulcer of the leg when the patient takes to his bed and elevates the part. What applies to the blood tension of the rectum applies also to that of the testicle and probably in a more marked degree, since while lying on the back the testicles are more elevated than the rectum. In treating the testicle blood tension can also be diminished by outside pressure, in extreme cases by the elastic bandage, but more commonly by a firm packing of lamb's wool. Cotton is of little use for this purpose, since it has little inherent elasticity. These methods apply only to the testicle itself and not to the cord, position alone affecting the blood tension in that part.

Other conditions which call for the use of the suspensory bandage are traumatism, tumors of the testicle, cord, scrotum, etc., hydroceles of various kinds, varicoceles, neuralgias and convalescence after surgical procedures affecting the parts. Sometimes also the bandage is used simply to keep the testicles up out of harm's way, as is seen among horsemen, athletes, etc., though such support, it seems, should rarely be required in the absence of any pathological condition. Aside from conditions of traumatism, neuralgia and convalescence after operation in the above list the surgeon is loth to prescribe the bandage except as a temporary expedient, active operative interference being naturally advised in all cases where the general conditions warrant.

The abuses of the suspensory bandage (which of course do not include instances in which ill-fitting appliances are used, as this subject as already been considered) can be grouped under two headings: (1st) Instances where the support has been wrongly or needlessly prescribed; (2d) Instances where the support prescribed for a temporary use has been worn permanently.

The first of these instances applies largely to credulous and rather stupid individuals who have consulted advertising mediums oftentimes for loss of sexual power, spermatorrhœa and kindred disorders and who have received as a panacea for all their troubles a suspensory bandage, usually highly elaborated, which is supposed to possess some occult power, much as the electric belt. Then, again, it is customary with some practitioners to order the support without making an examination of the parts as a result of vague complaints directed toward the genito-urinary region. The abuses comprised under the second heading need no further explanation. As a result of these abuses one often finds that the patient consulting him has worn a suspensory bandage for years, though a careful examination of the parts at the present time may reveal no cause therefor. It will not do, however, for the surgeon under such circumstances to order the bandage immediately discarded, for if this is done the patient oftentimes suffers severely from dragging, neuralgic pains and the ability of the new consultant is liable to be questioned. Why this disagreeable reaction so often occurs is not clear, although probably it is largely due to the partial atrophy which must take place under such circumstances in the fibres of the cremaster muscle and in the supportive tissues owing to long disuse, thus allowing the parts when left

to themselves to drag unduly and to become much congested. The best advice, therefore, in order to get rid of the support, and there is no doubt if the parts are all right that they should be left free and natural, is to direct the patient at first to take it off for a short interval during the quiet part of the day, each day gradually increasing the interval, putting the support back when disagreeable sensations commence. After a time he will find that he can go all day without annoyance. It is, however, well to advise him to make it a temporary practice to carry the support in his pocket so that it can be applied in case pains set in after some especially violent exertion, an accident, which is liable to occur, until the parts have regained their former qualities of strength and firmness.

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GANGRENE OF THE SCROTUM.<sup>1</sup>

BY

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THE subject of the following brief history was an oysterman, 34 years of age, who was admitted to the City Hospital March 15, 1893. The only venereal history which could be obtained by my house physician, Dr. Haney, to whom I am indebted for notes of the case as well as for two of the drawings which I shall pass for inspection, was that of gonorrhœa eight years before, and a chancroid followed by suppurating bubo some three months previous to admission. Eight days before coming under observation, and while under the influence of alcohol, in which he indulged freely, patient became conscious of a dull pain in the region of the scrotum, which came on, he thinks, after lifting some heavy object. The parts soon became involved in a general swelling; the pain increasing with the enlargement during the succeeding four days, when the maximum was reached. Upon the fifth day a black streak appeared upon the lowest portion of this scrotal tumor, and an area of mortification extended slowly upward toward the perineum as well as anteriorly, until it involved at least three-quarters of the swollen organ. The pain subsided as this extension took place. There was no history of chill,

<sup>1</sup> Read at the Genito-Urinary Section of the New York Academy of Medicine, January 9, 1894.

chilly sensations, or other symptoms of fever, though the patient admits that he was much of the time under the influence of drink.

Upon examination the scrotum was found to be as large as a good sized cocoanut, forming an oval tumor, the greater part being covered with moist gangrenous skin of an ashen and in parts black color, showing a tendency to separate near a line of demarcation from a still uninvolved upper portion. The latter, however, was stretched and distended, and gave to the touch a decidedly emphysematous crackling in common with the whole tumor, from which a horribly foetid odor was given off. (See Fig. 1.) In the left groin was a granulating surface almost an inch in diameter, though on a level with the surrounding skin, which marked the site of the bubo already mentioned. This open wound arrested the attention by an unusual and peculiar brick-red color. The patient's general condition was good, in fact much better than one would expect. The functions were but slightly deranged, and the urine showed complete absence of both albumin and sugar. Hot charcoal poultices sprinkled with iodoform were applied, and in three days the gangrenous and sloughing tissues had separated and come away. Both testicles were now entirely exposed and pendulous. Upon the left side the tunics of the testis were found involved in the gangrenous process, but all the other tissues presented the same striking red color, which had been noted and was still present in the bubo wound. Posteriorly a bare fringe of scrotal skin remained at the margin of the perineum. Anteriorly upon the right side all had been lost up to the peno-scrotal junction and skin of the groin. Upon the left side in front the flap of skin left intact, as shown in Fig. 1, had so retracted that scarcely any covering for the testes appeared to remain. For some days there was extension of the gangrenous area upon the tunics of the left testis with increased pain, but under aristol dressings, mild antiseptic douches, and support of the parts, healthy granulations sprang up as the gangrenous tissues separated, and the testicles now retracted within the embrace of the gradually elongating and growing shreds of scrotal skin. The groin ulcer had now entirely cicatrized under aristol.

The appearances presented at about this time are shown in Fig. II. By the tenth of April portions of the newly forming scrotum which was being encouraged to grow in proper direction by the application of traction strips, had formed adhesions with the external surface of the tunics of the right testicle,



leaving the greater portion of the latter uncovered. I now dissected up such flaps as were adherent, and freshening the edges upon both side was enabled to approximate them, though not to make them meet. They were retained in their new position by firm adhesive strips. Five days later these were removed and good union was found to have taken place, a small area remaining to granulate, as shown in Fig. 3. Healing took place



FIG. 1.

CONDITION OF SCROTUM ON ADMISSION, MARCH 15TH, 1893.

rapidly, and patient was discharged well six weeks from date of admission. The testes were freely movable within the scrotum, but slightly tender, and I have no doubt the patient went out into the world again, a man among men.

For the reason that so little is said in text-books concerning this condition I shall take advantage of my opportunity to elicit

from the members present as full a discussion as possible concerning the etiology, usually so obscure.

The factors which aid us in this case are :

1. Abuse of alcohol.
2. Indefinite history of indirect violence.
3. An open wound through which infection could have taken place.

Probably most instances of scrotal gangrene supervene upon

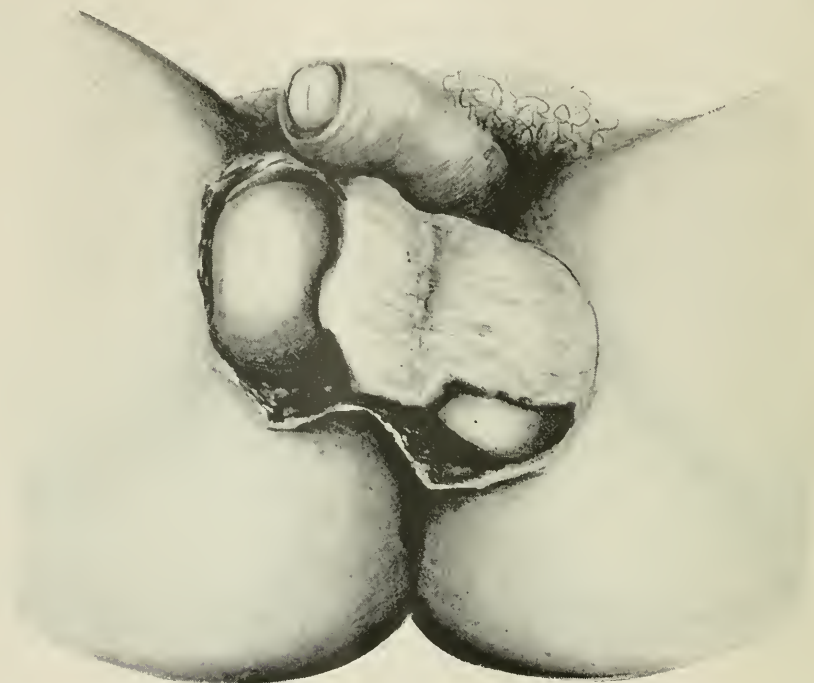


FIG. 2.

CONDITION AFTER RETRACTION OF TESTES, A WEEK OR TEN DAYS AFTER GANGRENOUS MASS WAS THROWN OFF. REPARATION PROGRESSING. MARCH, 1893.

extravasation due to injury of the urethra, but in the present instance the urethra was found in a healthy condition and there was no stricture nor history pointing to injury. Erysipelas is a not infrequent disease of the scrotum liable to be followed by gangrene due to the thinness of the skin and great degree of laxity of the cellular tissues.

As I have already mentioned in the chapter on Diseases of the Scrotum in Morrow's System, page 884, "Erysipelas may

be followed by gangrene of the scrotum and this is probably the origin of many obscure cases in which the cause of the gangrene is not found."

Although favorable conditions were here present for erysipelas to develop, there is total lack of history pointing to such an onset as well as lack of objective evidence in the region of the groin lesion.

It is, however, at the present time, I believe, considered possible for the streptococcus, having a given pathogenic

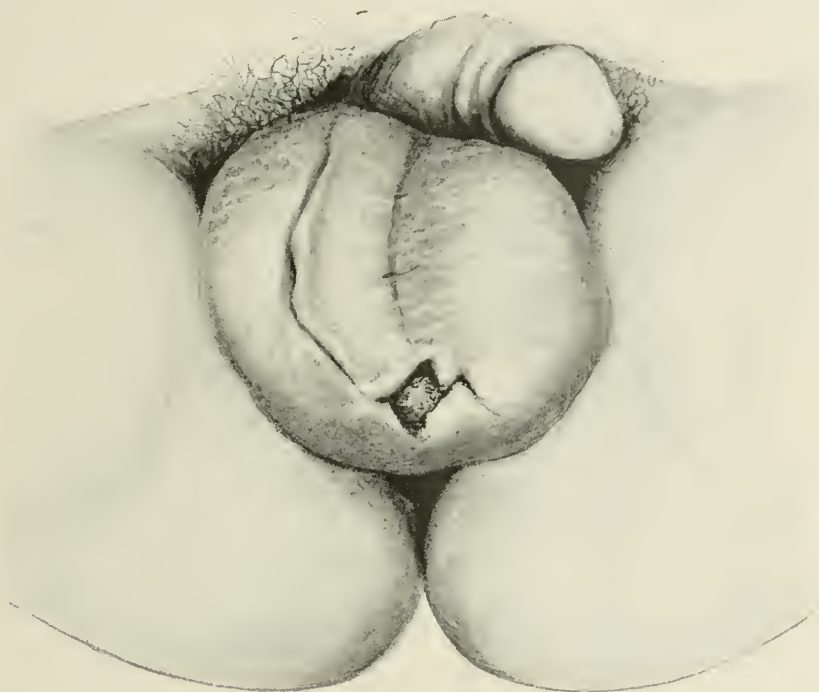


FIG. 3.

CONDITION ON APRIL 18TH, 1893, ABOUT TWO WEEKS BEFORE FINAL HEALING AND DISCHARGE OF PATIENT.

potency to produce erysipelas in those tissues which possess a certain degree of vital resistance, and to occasion gangrene in tissues whose resistant power is lowered, and especially if the so-called pathogenic potency of the microbe is for any reason increased.

Again, the possibility must be borne in mind of saprophytic

bacteria finding in the ulcer the necessary conditions for becoming pathogenic and acquiring gangrene-producing powers at a moment when some slight traumatism has favored their penetration to parts previously healthy. Arloing has strikingly shown how bacilli, incapable of determining a gangrenous process in healthy tissues, will do so when injected into tissues which have been contused.

In this case I have reported, a diminished blood supply from thrombus or embolism of a nutrient vessel might act much in the same way as a bruising of the tissues from external violence and furnish that amount of lessened vitality necessary for the micro-organisms to multiply with increased pathogenic power. Gangrene may begin in the testicle and extend secondarily to the scrotal tissues now and then. Gerster has recorded such an instance, and I take it that this was the condition present in a case reported by Olivier in 1837, where one testicle was cast off along with the entire scrotum. It also seems possible for subscrotal or testicular suppurative processes to impress a gangrenous character upon the tissues in its outward extension, as instanced in a case recently reported by Büngner. The subcutaneous development of gangrene is also seen in noma, where a bluish discoloration is transmitted through the skin surface, as it were, before the latter can be said to be in a state of actual gangrene. As having a possible bearing upon our case, I wish to refer to a number of clinical observations of scrotal gangrene in which lesions in the region of the groin have been recorded.

To go back to the time of Devergie, we find in his atlas three cases. In the first there was an ulcer at the root of the penis; erysipelas of the scrotum followed by gangrene and death.

*Case II.* Inguinal adenitis. Operation—erysipelas—gangrene exposing testicles—recovery.

*Case III.* Bubo incised—erysipelas—gangrene exposing testes—death.

About 1885 Winslow, Jones, Tiffany and Platt in this country placed on record four cases in which gangrene of the scrotum supervened upon operation for removal of inguinal glands. In one patient erysipelas had plainly preceded the gangrene, and one case resulted fatally.

In explanation of these cases Platt (Med. News, 1885, XLVII.) looks to the nervous system and attributes the gangrene to ilio-inguinal nerve irritation reflected to the terminal filaments in the scrotal tissues. In support of this view he in-



stances the reflex gangrene of the laboratory and the symmetrical gangrene of Raynaud's disease under the influence of the nervous system. Now while we have had our minds directed to the fact that the scrotum and groin are supplied from the same nerve trunk let us take one moment more and recall how the fascia of the groin is continuous around the base of the scrotum with the dartos and how the lymphatics of the organ terminate in the inguinal glands, and I submit if it is not more rational to look for bacillary infection along the course of these favorably directed tissues than to invoke a reflex trophic disturbance in explanation.

One of the most recent records of scrotal gangrene is that contributed by Büngner in which, shortly after influenza, painful swellings appeared in the groins and were followed within a few days by gangrene which denuded the testes, a suppurating gland remaining in the groin from which cultures of the staphylococcus pyogenes aureus were obtained. The marked emphysema in our case might lead the bacteriologist to look for the bacillus aërogenes capsulatus, now so often discovered in cases of gaseous gangrene, or other gas-producing micro-organism, Koch's bacillus of malignant œdema, or, possibly even the bacterium coli commune which Chiari has just discovered in a septic emphysema following gangrene of the leg.

From the clinical side alone, supported by the instances I have enumerated, I think we may say that suppurative lesions in the region of the inguinal glands favor the development of scrotal gangrene. Among the causes of this distressing and often dangerous condition, aside from urinary infiltration, erysipelas, thrombosis, embolism and incidentally influenza, which have been mentioned, we find typhus, syphilis, gonorrhœa, diabetes, prostatic disease, pediculi pubis, ergotism, traumatism (faulty punctures and injections) and frost-bite referred to. The explanation given by Olivier, who attributes such cases to a "concentration of the inflammatory process," seems worthy of reproduction. He says, "*Il me semble que cette gangrène tient plutôt à la violence de l'inflammation qu'à sa malignité. La nature en concentrant tout le principe morbifique sur ces parties, en a anéanti l'action vitale, c'est une crise dont elle se sert quelque fois, et qui, par son mode d'action peut être salutaire.*"

The idea of there being anything especially salutary in the loss of the scrotum and perhaps one or two testicles does not appeal strongly to modern mode of thought.

One word more to draw the precept from the text—in these cases don't castrate! This may seem to the present company superfluous advice, but it wasn't so long ago that a gentleman having such a denuding gangrene to contend with looked in his books and not finding any instructions, snipped the cords.

Indeed, this practice seemed at one time so prevalent that a physician near Boston entitled his report "*Gangrene of the scrotum in which the testicles were not removed.*" Instances in which the testes have been sacrificed abound in this as well as other countries, and even to-day this little word may help some young man somewhere to remember that no matter how little scrotal tissue remains it is not to be despised.

#### A CASE OF CIRCUMSCRIBED SCLERODERMA (MORPHŒA).<sup>1</sup>

BY

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MARY M—, aged ten years, an intelligent looking girl, well nourished, although slightly pale, came under observation September 4, 1892, with variously sized and colored spots on the left upper extremity which began to appear two years previously. They were all situated on the extensor surfaces, and presented different stages of development. The first to appear, and the one showing most perfectly the typical features of the disease, was situated on the forearm at about its middle third. In shape it was oblong, measuring four inches in its long diameter, which corresponded to the long axis of the limb, and two inches transversely. It was slightly contracted, at one point, noticeably lessening the circumference of the forearm, and depressed below the general surface of the skin, at first sight, and more especially in the center, suggesting scar tissue. More closely examined, it presented a central zone of yellowish-brown or wash-leather tint, darker at the margins, with a slightly uneven or worm-eaten surface, slightly hard when taken between the thumb and finger, not adherent to the subjacent structures and retaining its normal sensibility. No hairs were visible in this zone. Outside of this central zone came a bluish-white belt, fairly well-defined, which was surrounded by a lilac-pink colored border which merged into the

<sup>1</sup> Read before the Seventeenth Annual Meeting of the American Dermatological Association, at Milwaukee, September 4, 5 and 6, 1893.

normal skin. About the patch the veins were large and unusually prominent. When first noticed by the patient the lesion was about the size of a quarter of a dollar and of a whitish color.

The second spot in size, and the next to make its appearance, one year later, was situated on the back of the hand near the base of the index finger, extending outward over the metacarpal bone of the thumb. It was irregularly oval in shape and presented the main features of the lesion already described.

During the four months preceding her first visit to me, eight other spots appeared, seven on the arm and one on the shoulder over the spine of the scapula. These were all smaller than those on the forearm and hand, irregularly round, except at the elbow, where they coalesced, forming an elongate or irregular group, of a whitish color surrounded by a slightly tinted pinkish, and in places lilac border. Taken between the thumb and finger there was some induration, but the spots were not raised above the surrounding skin. The patient complained of occasional sharp pains extending from the back of the shoulder down the extensor surface of the arm to the middle finger of the left hand. These pains came for the most part while in school, especially when she was writing. They came three or four times a day for a few days, then stopped for a while. When practicing on the piano she complained of fatigue in the left hand, and especially the middle finger. There was, at times, slight itching around the margins of the lesions.

Occasional frontal headache was also complained of. This was sometimes induced by jarring or suddenly turning the head. There was marked tenderness on percussion over the upper dorsal and lower cervical vertebræ, and the patient informed me that there was a dull, aching pain in this region which sometimes became sensitive even under the weight of her clothing. Sensibility to tactile and painful impressions was unimpaired both in the limb and in the spots themselves. There was no paralysis in any muscle or group of muscles. The pupils were equal and reacted to light. The knee jerks were equal and moderate. There was no ankle-clonus.

Previous to the onset of the disease the patient had always enjoyed good health excepting during the early years of childhood, when she had, at different times, whooping cough, mumps and measles. Upon inquiry the mother stated that the patient had fallen from a baluster, striking her back, when five years old. It was not regarded a serious injury, as it gave rise

to no noticeable discomfort, and was well nigh lost sight of, until recalled by the tenderness over the upper part of the spine.

The patient has one brother, aged thirteen, and a sister aged three years. Both are robust and well developed for their age. The father assured me he had never had any venereal disease, and excepting his mother and two of his brothers, who died of phthisis at an early age, the family on both sides had been long-lived and unusually free from disease. No history of any nervous disease could be obtained.

September 1, 1893, the patient was again seen after nearly a year's absence. The appearance of the arm had greatly changed and the original conformation, excepting on the back of the hand and over the scapula had disappeared, giving rise to a continuous band of indurated scar tissue from one to two inches in breadth, extending from the shoulder to the lower third of the forearm. In straightening the arm the contraction of the diseased tissue became strikingly apparent. Over the elbow the purple plaque had changed to a dark brown color. The primary lesion on the forearm, as well as the one on the back of the hand, were of a darker, or mottled-brown color. The same lilac border was present although its tint was softened. The diseased skin, which was almost cartilaginous in places, was also more firmly adherent to the subjacent structures, presenting a true picture of scleroderma in its atrophic stage. There was no pain or other discomfiture in the limb, although the sensation was diminished in the parts first involved. In grasping my hands I detected a marked weakening in the affected side. The tenderness in the back continued with no perceptible change. During the past four months two spots have appeared on the opposite arm and forearm, in position and objective features corresponding to those already described. The one on the forearm was three-quarters of an inch in its long diameter, on the arm the lesion was about the size of a dime. There was no pain or sense of fatigue complained of in the right arm.

In the evolution of this disease, extending over a period of three years, there has appeared a decided change in clinical appearance. At first the case presented nothing unusual in its cutaneous manifestations, and I regarded it a perfect type of the disease *morphœa*. But the eruption did not end here, and now it presents the picture of scleroderma in the atrophic stage. There are certain features, too, connected with the case that seem worthy of mention in this connection.



*First.* The case is of interest in showing the change in clinical form through which the disease has passed, and as an instance of atrophic changes indistinguishable from scleroderma, supervening on a typical case of morphœa.<sup>1</sup>

Dr. Duhring in fifteen cases of morphœa did not observe any of the well marked symptoms pertaining to scleroderma, (*Dis. of the Skin*, 3d edition, 1882, p. 405), and treats of these diseases as separate affections. From another standpoint, Dr. Van Harlingen, in a careful analysis of twenty-eight cases of scleroderma, did not observe a single instance in which morphœa was present. (*Am. Jour. Syph. and Derm.*, October, 1875.)

*Second.* As to the neurotic element, which in morphœa is often well marked, and in this case has given rise to prominent subjective symptoms. These point to the spinal cord as the most probable seat of disturbance. Whether or not the injury received in childhood bears any relation to the tenderness now complained of in the back, or to the changes in the skin, one may not be able to say. Yet, as no inconvenience was complained of after the receipt of the injury until about two years ago, and after the lesion was first noticed on the forearm, its association at this late day seems highly improbable. Since severer forms of trophic disturbances, as in Morvan's disease and in syringo-myelia, are occasioned by destructive lesions in the anterior cornua of the cord, and as in the case herein reported there is marked tenderness over some of the roots of the brachial plexus which supplies the cutaneous regions affected, it seems not improbable to suppose that the disease originates from some as yet unknown changes in the spinal cord. Further, as there are no evidences of structural lesions in the cord, and as morphœa tends to a final recovery, these changes are probably functional rather than structural, or more properly anæmic rather than inflammatory in character.

*Third.* Concerning the nomenclature of the disease, as well as the relation of morphœa to other dermatoses of this group, there is much confusion in medical literature. And in making a diagnosis one is confronted with a variety of terms that have from time to time been applied to this disease. According to some, who hold the identity of morphœa with scleroderma, the disease was pointed out by Alibert<sup>2</sup> in 1817, as *scleremia cir-*

<sup>1</sup> See further on this subject, Hutchinson, *Clin. Lectures*, Vol. 1, page 318.

<sup>2</sup> Sydenham Society's Publications. Vol. xxxvi. London, 1869, containing article by Dr. Thomas Addison on the keloid of Alibert, and on the true keloid, read before the Royal Medical and Chirurgical Society, 1854.

*cumscripta*. Others believe that the disease pointed out by Addison as "the true keloid," subsequently christened morphœa by Wilson<sup>1</sup>, is a disease *sui generis*.

Dr. Hilton Fagge (Guy's Hospital reports, 1867), who has studied the keloid of Addison in detail, regards it as identical with scleroderma of the German and French authors.

Since the publication of Dr. Fagge's report most modern English writers have classed morphœa, or the keloid of Addison, as a variety of scleroderma, which is also true of modern French and German writers. In America, however, this consensus of opinion does not obtain, and in modern treatises on dermatology by American authors more than half of those consulted treat of morphœa and scleroderma as distinct affections.

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## HEMORRHAGIC EMISSIONS.<sup>2</sup>

BY

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VERY little has been written upon the subject of hemorrhagic emissions, yet I have become convinced that an admixture of blood with the seminal discharge is not only more frequent than is generally supposed, but is often due to causes that are imperfectly understood. I shall not endeavor to present all of the illustrative cases which have come under my observation. Some of them were met with at a time when I was not particularly interested in the subject in hand, and others in which I have made full notes would merely be a repetition of the several classes of cases comprised by the series presented in the present paper.

*Case I.* A professional gentleman, 38 years of age, presented himself with the following history: he was considerably run down from overwork and had been a sufferer for some time with pronounced neurasthenia, which, in his opinion, was sexual in character. He had never had any injury of the genito-urinary tract, but had experienced a protracted gonorrhœa many years before he came under my observation. For some

<sup>1</sup> Wilson, Diseases of the Skin, 3d Edition, London, 1867.

<sup>2</sup> Read before the Southern Surgical and Gynecological Association, 1893.

months he had observed that after the sexual act he had quite a profuse hemorrhage from the urethra, which lasted for some little time, and which was followed by hematuria, lasting for a day or so, and disappearing without leaving any bad effects. There had been some irritability of the prostatic urethra, but the symptoms indicative of this were by no means pronounced. When he first noticed his difficulty there was no hemorrhage after the act of copulation, and he supposed that the condition of affairs was explicable by the sudden appearance of the menstrual discharge in the other party to the act. There had been no obstruction to the urinary outflow. Aside from the inconvenience and embarrassment incidental to the hemorrhage, he was considerably disturbed in mind by the suspicion that a tumor might be present in the urethra or bladder. Examination detected a congested and irritable stricture of large calibre in the pendulous urethra at a depth of three and one-half inches from the meatus. The gentlest possible manipulation with the exploring bulb caused quite profuse hemorrhage. The prostate, bladder and seminal vesicles were apparently normal. The explanation of the hemorrhagic ejaculations in this case was obviously very simple. Dilatation of the stricture relieved this particular symptom completely. The stricture, however, being irritable and resilient, was subsequently operated upon.

*Case II.* A young man, 28 years of age, presented himself to me with a somewhat similar history as that of Case I. Patient in this instance, however, was a very healthy and powerful man, who had had distinct symptoms of stricture for several years. He had had a "light attack of syphilis," as he expressed it, at about the age of twenty. In this case the hemorrhage attendant upon the emission was not only profuse, but lasted in greater or less amount for several days. The patient himself had formed a correct opinion as to the source of the blood. I found in this instance several strictures in the penile portion of the canal, and a moderately tight perineal stricture. There were slight fullness and tenderness of the prostate and seminal vesicles. I suggested operation upon the penile strictures, which was declined, the patient preferring to rely altogether upon dilatation, which proved eminently satisfactory, so far as the relief of his symptoms was concerned.

*Case III.* A perfectly healthy man, 32 years of age, who had been continent for a prolonged period, and who had never had any venereal disease, presented himself to me with a his-

tory of nocturnal emissions characterized by a very profuse admixture of blood with the seminal discharge. On inquiry I found that the continence of this patient, like that of many other men, was a relative matter, inasmuch as he allowed himself unbridled license short of actual physical indulgence. He was a high liver and by no means abstemious as regards alcoholics. Careful inquiry readily elicited the cause of his difficulty. He had been engaged for some months, with the resultant sexual stimulation without gratification that is usually attendant upon protracted engagements, where the parties to the contract are intimately associated. In addition to this sexual factor in the production of his trouble, he had been indulging in familiarities with various women without the natural method of relief. The prostate in this case was moderately tender and swollen; the seminal vesicles also somewhat enlarged and tender. Proper instruction in sexual hygiene, the liberal administration of ergot and bromides in combination with the occasional introduction of the cold steel sound relieved this case completely. He has since married, and as far as I am able to learn, has no complaint to make regarding his sexual function.

*Case IV.* A young man, 18 years of age, consulted me regarding frequent and painful nocturnal emissions, from which he had suffered for about three months. These had come on in the course of a posterior urethritis from which he had suffered from four to five months prior to the beginning of the symptom for which he consulted me. The semen was mixed with considerable blood. There had been the usual symptoms of vesical irritation characteristic of posterior urethral inflammation. He stated that at one time vesical symptoms had been quite severe; there had been some obstruction to urination. There was no hemorrhage after ejaculation. The symptoms had been attributed by his physician to inflammation of the prostate. Examination revealed a posterior urethritis, and a prostate and seminal vesicles which were considerably enlarged and very tender, the seminal vesicles particularly being exquisitely tender. There was no stricture of the urethra. The patient was given careful instruction in sexual hygiene and a mixture containing bromide of potassium, ergot and gelsemium in full doses. As the tenderness of the prostate began to subside the careful use of sounds was begun. Considerable benefit was obtained in this case, but the patient was very hard to control and disappeared from my observation before a complete cure



was effected. The subsequent history of the case I know nothing of.

*Case V.* A young man, 25 years of age, presented himself to me with a history of a gonorrhœa of three months' duration. He had experienced several previous attacks which, according to his story, were very mild. He had noticed for some time that his ejaculations were not only painful, but the semen was mixed with a considerable quantity of blood. This symptom was present both in normal intercourse and in association with nocturnal emissions, which had latterly become quite frequent. There had been the usual symptoms of vesical irritation met with in cases of posterior urethritis. There was no hemorrhage in the intervals between ejaculations. The meatus was quite narrow. The pendulous urethra was approximately normal, but the prostate and seminal vesicles were considerably enlarged and exquisitely tender.

*Remarks.*—It is evident upon even a casual survey of the cases I have presented, that they comprise three distinct types of hemorrhagic emissions, each dependent upon a different cause. In Cases I. and II. the explanation of the admixture of blood with the semen is very simple. A congested, or perhaps inflamed condition of the mucous membrane existed at the site of a stricture of greater or less duration and extent. The venereal orgasm under such circumstances might be expected to produce more or less traumatism of the diseased portion of the urethra. A splitting of the mucous membrane being produced mechanically, a greater or less degree of hemorrhage ensued. Part of this hemorrhage was admixed with the semen as that fluid passed over the diseased urethra. The hemorrhage in such cases is likely to persist for some little time after the completion of the venereal act, and gives rise to hæmaturia. This class of cases is not very infrequent.

Case III. is a rare and, to me, a very interesting one, as showing the intense hyperæmia of the seat of sexual sensibility and, possibly, also of the seminal vesicles which may result from prolonged sexual excitement. Such cases are not likely to be difficult of cure, if the patient be tractable.

Case IV. and V. represent, perhaps, the most frequent variety met with in practice. The blood in such cases originates in a seminal vesiculitis and inflammation of the posterior urethral mucous membrane. The indications in the several cases vary somewhat. In the case of stricture of the urethra, which is producing hemorrhage at the time of emission, the treatment

should be the same as in cases of stricture which are free from such hemorrhagic manifestations as those which have been described. Some cases will yield very readily to dilatation, urethrotomy, however, being required in quite a considerable proportion of cases. Where there exists seminal vesiculitis, I have found the cases very stubborn to handle when the urethral inflammation settles down, so to speak, to a condition of chronicity. Even in these, however, cure of the ejaculatory hemorrhage usually results. Careful attention to sexual hygiene, the irrigation of the rectum by hot water, and the internal administration of ergot and bromides, have appeared to me to be of some value in these cases. It is well to remember the practical point, that in any case of urethritis which is followed and attended by painful and hemorrhagic emissions, seminal vesiculitis with or without posterior urethritis is likely to exist. It is obviously a very difficult matter to apply any typical remedy whatsoever to the seat of the hemorrhage-producing disease. It is impossible to apply antiseptics or astringents to the posterior urethra in such a manner that the prostate will be anything more than superficially affected. Personally, I incline toward irrigations of the deep urethra by means of the short urethral nozzle as being the most effective plan of medicating the posterior urethra. I have said nothing of tumors and tubercular disease as a cause of hemorrhagic emissions—such cases quite likely occur, but I have not happened to meet with them. Nor have I seen, as yet, any case in which this symptom could be attributed to testicular disease.

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#### THE TREATMENT AND CARE OF CHANCRE WITH PEROXIDE OF HYDROGEN.

BY

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THE subject of the best treatment of the primary sore of syphilis has occupied the minds of investigators of late years to such an extent that almost every surgeon has a different method, and the general practitioner is somewhat at a loss to know which is the best treatment to employ as the most expeditious means of relieving the anxiety of the patient and curing the lesion. The special purpose of this paper is to draw attention to a particular method of treatment which not only relieves the anxiety of the patient and places him in a delight-

ful buoyancy of mind, *but cures the chancre in the shortest possible time* without pain or detention from business, and with less scar and less destruction of tissue than any other method.

The chancres of the following cases, selected from a good many recorded, were of the large Hunterian variety, embracing the worst forms of sloughing and phagedena.

*Case I.* Mr. K., aged 38 years, came to me January 29th, 1891, with a large sloughing single chancre, situate on the right side and at the base of the glans penis at the junction of the prepuce and very deep; incubation about thirty days; penis large and soft. Sprayed it with full strength solution (15 volumes) of peroxide of hydrogen at 60 pounds pressure, and dressed with iodol powder, and continued the same treatment every morning at 7 o'clock.

February 20th, sprayed it as above; sore now only skin deep, and continued till February 23d; sore healed; duration of treatment twenty-five days.

*Case II.* Mr. W. B. came to me September 6, 1892, with a single sloughing chancre on left glans penis, and corresponding ulceration on prepuce; incubation about thirty days; sprayed with peroxide of hydrogen, full strength, 60 pounds pressure, and dressed with iodol; continued same treatment every evening at 7.30 o'clock for sixteen days.

September 23d, sore almost healed.

September 25th, sprayed for the last time to-day; duration of treatment, nineteen days.

*Case III.* Mr. L., aged 28 years came to me August 23, 1893, with a phagedenic chancre, thirty-five days' incubation, situated immediately at meatus urinarius, and sloughing its way very rapidly into the urethra; sprayed it with peroxide of hydrogen, full strength, 60 pounds pressure, and dressed with iodol powder. Continued the same treatment every evening at 7.30 o'clock.

August 30th. Sore almost healed up, only some granulations left. Continued the same treatment every evening till September 4th. Sprayed it to-day for the last time; there only being the surface of the sore about the size of pin's head. Considered himself cured and said he would not come again. Duration of treatment, eleven days.

The above cases, selected from many recorded cases, on account of their possessing the worst features of the initial lesion, serve as good examples of the treatment by the peroxide of hydrogen method.

I treated Mr. K., of Case I., on two different occasions for the same disease in exactly the same manner, and the two cases are about identical in regard to length of time of treatment and as to details, and he got well in about the same manner.

The case of Mr. L. presented the worst features of phagedena, which was so virulent that I think he would have lost the greater part of the glans penis if he had been treated by the nitric acid or caustic method, and, as it was, the ulcer healed with a very small scar, almost unnoticable.

The pressure of the spray (60 pounds), which is one of the most important factors in the whole method, not only cleanses and produces thorough asepsis of it, killing the germs of the disease at the very bottom of the ulcer, but the oxygen of the peroxide aërates the blood through the capillaries, and arrests the progress of the disease at the nearest possible point, allowing the process of repair to commence as soon as possible, according to the severity of the disease, with the least loss and destruction of tissue and consequent scar. It must be particularly understood that in using this treatment all instruments, spray-tubes and bottles must be made of either glass or hard rubber, for the reason that metals, with one or two exceptions, coming in contact with the peroxide will destroy its component parts and render it useless, and I have found also a great difference in the results if the peroxide is fresh or otherwise. The first effect of a spray of peroxide upon the ulcer is to deposit upon it a thick film of albumen; this should be allowed to remain for about half a minute or less; then continue the spraying till a large tubefull has been used (one ounce); as the sore progresses the spraying causes a good flow of rich arterial blood upon it which merely shows returning healthy conditions.

The treatment is entirely painless and the patients do not experience any annoyance or inconvenience whatever while carrying the disease, and freely express themselves as well pleased with its effect.

No internal medication during this stage is given. The iodol powder is used only as an antiseptic to protect the sore from external influences until it is sprayed again the next day, keeping the sore in as good a condition as it is left by the spraying, which must be done once every day until the ulcer is healed.

This method of the treatment of chancre has been in my hands the best and most successful of all methods that I have heretofore adopted.

120 West Forty-ninth Street.



## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

#### 228TH REGULAR MEETING.

DR. C. W. ALLEN, *President, in the Chair.*

#### A Case of Spontaneous Corns on the Finger.—Presented by DR. ELLIOT.

The patient was a female, aged 16 years. She had always been very nervous and excitable, and somewhat hysterical. She is not employed at any trade nor does anything but housework. About one month ago, one lesion developed on the ulnar side of the middle finger of the left hand, and since then some eight or ten more have appeared on the same side, more or less grouped over the distal half of the second and third phalanx. There is also one at the root of the same finger, and at the root of the little finger of same hand. Ordinary verrucæ are also found here and there on both hands. The lesions represent typical clavi, and are painful to the slightest touch. They are apparently spontaneous in origin.

DR. FOX said that at the first glance it appeared to him that all the lesions were of the same nature. It is true that on one finger the growth was a typical seed-wart, while on the other finger the lesions had a corn-like appearance, but still he was inclined to think that the same papillomatous process existed at the base of all the tumors; that in one case the epidermis had been split, while over the others it was still smooth and firm.

DR. CUTLER was of the opinion that if the growths were left entirely alone they would in a short time become ordinary seed-warts. Clinically speaking it is not unusual to find lesions on the fingers, which at first appeared in the same way as those in the case presented by Dr. Elliot, with a small central depression, and in the course of a few weeks or a month or more develop into ordinary warts.

DR. SHERWELL said he regarded the growths as ordinary warts. He inquired which of the tumors appeared first, the seed-wart or the so-called corns? the point of interest being that of possible contagion.

DR. ELLIOT replied that the corns appeared first.

DR. KLOTZ also regarded the growths as undeveloped warts. He inquired whether corns ever develop spontaneously—that is, without a history of injury?

DR. ALLEN said he is strongly of the opinion that warts are contagious, and if the so-called seed-wart had come first the clinical appearance of the other lesions would certainly not invalidate the diagnosis that all the growths are of the same nature.

DR. ELLIOT stated that the lesions on the girl's middle finger were pared down to the quick without showing the slightest evidence of papillary outgrowth. If there is no papillary outgrowth you cannot have a wart, although it is perfectly possible, pathologically speaking, to have a papillomatous outgrowth appear later on; this is very frequently seen in corns on the feet. The growths on this girl's middle finger, Dr. Elliot said, are clavi

so far as their histological characters are concerned. The occurrence of spontaneous clavi on the palms of the hands is not very unusual. Kaposi, Crocker and other authors have reported such cases. There is a very distinct pathological difference, however, between a clavus and a wart.

DR. KLOTZ said the localities mentioned by Dr. Elliot were certainly exposed to some pressure and injury. A wart at first simply shows as a horny elevation, then a small depression appears in the centre, and later on papillæ will develop.

DR. ELLIOT said that primarily we may have an epidermic hypertrophy, and secondarily a papillomatous hypertrophy.

DR. FOX said that a wart can be picked out with the curette, leaving a punched-out hole in the corium; this you cannot do with a corn on the toe, no matter how hard you scrape.

**A Case of Telangiectasis of Unusual Development.**—Presented by DR. MORROW.

The patient was a girl aged 10 years. Shortly after birth the child became subject to convulsive seizures, due probably to some central lesion. These attacks continued for a period of about twelve months, the child sometimes having as many as one hundred seizures in one day. During the course of these attacks, when the child was five months old, unusual patches of telangiectasis developed on the face and body. There is a large, diffuse, irregularly oval patch on the left cheek and another about the size of a silver quarter under the chin; the latter appears to be undergoing spontaneous involution. Three or four years later a large number of minute lesions appeared on the face, distributed over the nose and malar regions, suggesting the bat-shaped arrangement of lupus erythematosus, and these have remained with scarcely any change since. On the back there is a large cicatricial mark, several square inches in area, keloidal in appearance, which the mother states followed the application of a mustard plaster. On the opposite side of the body there are a number of cicatricial points, that seem to have developed spontaneously. The child is weak-minded.

DR. BRONSON regarded the case essentially as a fibromatosis. In many respects the growths were keloidal in character, although they differed from the true keloid. In the lesion on the back there appears to be an hypertrophied cicatrix, differing from the ordinary hypertrophied cicatrix in the fact that the epidermis over it has not been destroyed. The sinapism to which the origin of this lesion is traced probably caused an inflammation of the derma, but did not destroy the epidermis. As regards the patches of telangiectases on the face, Dr. Bronson said he supposed they were due to a similar hyperplastic process. A very interesting point in connection with the case is the mental condition of the child. In cases of fibromatosis, especially in molluscum fibrosum, we frequently find the mental condition of the patient below par. The question arises whether there is a similar fibrous degeneration in the nervous system.

DR. SHERWELL said he was fully in accord with the sentiments expressed by Dr. Bronson as to possible etiology.

DR. FOX said he could hardly believe that the application of a mustard plaster had anything more to do with the patches on the back than it had with those on the face. At least, some of the lesions were beyond the reach of the sinapism. To speak of the keloidal nature of these growths rather

helps to confuse the diagnosis; certainly, the lesions on the back do not appear to be cicatricial in character. He thought the term fibro-angioma would properly apply to the case.

DR. KLOTZ referred to a case of diffuse keloidal growth he saw several years ago which followed the application of green soap, which is not a much stronger irritant than sinapis.

DR. LUSTGARTEN said he would separate the lesions on the face and the body. Those on the face, he thought, belonged to the class of *nævi*, the histological character of which we are just beginning to study. Some of them have only lately been demonstrated to be an adenomatous condition of the sweat glands. These *nævi* are congenital, beginning to develop a short time after birth and progressing until puberty is reached. The lesions on the child's back, he thought, originated from a dermatitis, pustular in character, the result of an irritant—probably the mustard plaster. The two sets of lesions presented such different clinical features that he would separate them and thus simplify matters.

DR. MORROW said he was rather taken aback by Dr. Bronson's statement that he regarded the case as a fibromatosis. The face lesions were the ones he deemed of special interest. The cicatricial lesions on the back he had discovered by accident only a day or two ago. The larger one of these was undoubtedly due to a dermatitis resulting from the application of mustard. He desired to get the opinion of the members as to whether the patches on the face were amenable to treatment by electrolysis.

DR. BRONSON said he would be extremely apprehensive of the use of electrolysis, lest the application be followed by very thick cicatrices.

DR. MORROW stated that he prescribed a mixture of sulphate of zinc, sulphuret of potassium, glycerine and rose water, under the use of which the patches appear to have grown fainter.

DR. LUSTGARTEN said that if the lesions are *nævi* we do not know how deep into the corium the changes extend. If they are very deep we must destroy the skin, thus producing disfiguring scars; but if the changes are merely superficial, the cosmetic effects obtained by electrolysis may be excellent. The application of a weak current (about one milliampere) over a limited area is worthy of trial.

DR. MORROW said he had treated half a dozen or more cases of *nævi* of the face with very good results by boring into the center of the growth with a piece of orange-wood, sharpened at the end and dipped into carbolic acid. There is such an infinitude of lesions in this case, however, that this method of treatment is impracticable.

DR. ALLEN suggested that the treatment by means of electrolysis be tested on lesions remote from the face.

DR. FOX said he has had considerable experience with electrolysis in vascular *nævi* and found it very efficient. In this case, however, he feared that electrolysis would tend to increase the development of fibrous tissue. He would prefer to treat a very small patch on the face with caustic pyrozone, which perhaps acts a little better than carbolic acid.

DR. KLOTZ suggested the use of ichthyol and collodion in ten to twenty per cent. solution. Ichthyol, he thought, would have a tendency to decrease the vascularity of the lesions. He had seen an extensive hypertrophic scar produced by carbolic acid burning disappear under the continued use of iodoform collodion.

**A Case for Differential Diagnosis Between Syphilis and Tuberculosis.—**  
Presented by DR. MORROW.

The patient was a man, aged 45 years; married; had an attack of gonorrhœa when 18 years old, followed by a painful swelling in the left groin which lasted six weeks. About the same time he had an inflammation of the epididymis of the left testicle and sores on the scrotum. No history of any general eruption. The man's wife died from heart trouble. She had one child, which is still living, and one miscarriage at four months.

In 1889 the man began to complain of straining and difficulty in urination. He came under the care of a surgeon who, in the Fall of that year, removed one of the man's testicles on the assumption that it was tubercular. In April, 1892, the man married for a second time. He has thus far had no children by his second wife. The point of interest in the case is that about one month ago the man came back to the surgeon, presenting an inflammation of his scrotum and remaining testicle, and the question arose whether the case was one of syphilis or tuberculosis. There were two or three ulcerative lesions at the root of the penis, extending down on the scrotum, a large ulceration in the left inguinal region and another on the left side of the scrotum. Both the latter were covered with papillomatous proliferations. The entire skin of the penis was occupied by scar tissue, showing it to have been the seat of an ulcerative process. Dr. Morrow had regarded it as one of local tuberculosis, but, as a matter of precaution, he put the man on specific treatment, using mercurial plaster externally and potassium iodide internally. Under this treatment the sores on the scrotum and the inflammatory condition of the parts have almost entirely disappeared. The man states that previous to one month ago he had not taken any medicine for two years.

DRS. FOX and JACKSON stated that the appearance of the lesions on the scrotum and penis and the rapid improvement following the use of specific remedies seemed to indicate beyond doubt their syphilitic nature.

DR. KEYES agreed with Drs. Fox and Jackson. He referred to the value of specific treatment as an adjunct in clearing up the diagnosis between syphilis and tuberculosis in doubtful cases. He knew of many instances in which the testicle was unnecessarily removed. Even in cases of tuberculosis it was not necessary to extirpate the testicle if the epididymis or the tunica vaginalis alone were involved. It was necessary to remove all tuberculous tissue, otherwise the wounds would heal badly and fistulæ might remain.

DR. TAYLOR said that there was a tendency nowadays to pronounce all lesions of the testicles tubercular.

DR. ALEXANDER indorsed Dr. Keyes' statements. Where any doubt as to diagnosis existed it was worth while to put the patient on anti-syphilitic treatment, large doses of potassium iodide being particularly indicated. He mentioned a case in which the diagnosis of epithelioma of the testicle had been made, but which was rapidly cured by potassium iodide. In the present case the extensive ulceration and the appearance of the cicatrix on the penis very much resembled tuberculosis, and it would hardly be possible to clear up the diagnosis without the administration of anti-syphilitic remedies.

DR. SHERWELL agreed with the preceding members on the diagnosis of syphilis and strongly deprecated the ablation of suspected testicles and mu-



tilations of other parts, particularly of the nose, on suspicion of malignancy, or even what appeared proof thereof by microscopical examination, unless after specific medical treatment had been given a sufficiently long trial.

DR. ALLEN wished to add his protest against the indiscriminate extirpation of the testicles.

DR. MORROW said that he was not absolutely convinced that this case was one of syphilis, although the result of the treatment had been brilliant to a degree and entirely unanticipated. Still, he could not share the impression, which seemed to be general among the members, that because these lesions healed up under mercurial plaster and potassium iodide they were necessarily syphilitic. Tuberculous lesions may heal under the same treatment. The patient's prostate and seminal vesicles did not indicate any tuberculous involvement. The persistence of a fistulous opening was in favor of the tuberculous character of the lesions, and their papular character was distinctly tuberculous.

DR. PIFFARD said that those verrucose developments could be found fully as distinct in syphilis as in scrofulous conditions.

DR. KEYES referred to the value of potassium iodide in cases of tuberculous testis.

DR. MORROW gave the history of a case he had seen with Dr. Keyes in which an undoubtedly tuberculous epididymis and testicle healed under internal and local treatment with iodoform.

DRS. CUTLER and SHERWELL said that the improvement in the present case was much more rapid than could be expected in tuberculosis. In syphilis potassium iodide may be regarded as a virtual specific, but much less so in tuberculosis.

DR. KEYES said he ascribed the improvement following the administration of iodides in tuberculosis to the fact that it improves the quality of the soil, acting as a nutritive stimulant, and in this way destroys the life of the tubercle bacilli. Whiskey acted in the same way; a striking instance thereof had come to his knowledge.

DR. SHERWELL referred to the good and efficient action of specific treatment in other tubercular affections, when syphilis was present too, the two affections being symbiotic.

DR. ALEXANDER said that if we did not get good results with the iodides after a reasonably short time—say two weeks—we will probably not get them at all in cases where ulceration exists.

DR. KEYES said that where there were nodules rapid improvement might be expected.

DR. ALLEN said that when Dr. Morrow read a paper last year on syphilis and tuberculosis (Genito-Urinary Section, Academy of Medicine), and showed a case of dartyilitis which he regarded as syphilitic because potassium iodide had such a good effect on it, he had taken the opposite ground on the basis that many cases of tuberculosis did extremely well on potassium iodide. He then cited the case of a young man with tuberculosis of both testicles, who had wonderfully improved since being treated with iodide, locally as well as in regard to the general health. In reply to a question Dr. Allen stated that tubercle bacilli were not found in this case.

DR. PIFFARD inquired whether the tubercle bacilli are found in the majority of cases of tubercular testis?

DR. MORROW said that in the case narrated by him he had the urine

and semen analyzed, but no bacilli were found. Still, the case was a typical one, and Dr. Keyes pronounced it tuberculosis the very moment he glanced at it.

DR. ALEXANDER said that in the vast majority of cases of tubercular testes that have progressed at all the seminal vesicle on the same side is almost always involved; this is not so in syphilis. It is very difficult to find the tubercle bacilli, even where fistulous openings exist.

DR. PIFFARD said that, in his opinion, many of the so-called tubercular testes are not tubercular at all, but are syphilitic or sarcomatous.

**A Case for Diagnosis.**—Presented by DR. CUTLER.

The patient was a boy, aged 14 years; German. Some time ago a lesion made its appearance in the infra-maxillary region, near the angle of the jaw. This has gradually increased in extent until now it covers the entire infra-maxillary region on the left side and extends a little over the median line to the right side. The lesion was unaccompanied by any subjective sensations; no itching, burning nor pain, and it has not bothered him in any way excepting as to its appearance. The method in which the lesion has progressed was to gradually extend from the center towards the periphery, without healing up in the center. It is made up of small papules, which are quite soft to the touch and have a rather peculiar yellowish appearance. The papules are discrete, a few of them running together, but between them is to be found a small amount of cicatricial tissue and considerable atrophy of the skin.

Most of the members regarded the case as one of lupus vulgaris, superficial in character.

DR. PIFFARD thought it was a case of lupus erythematous.

DR. FOX said the localization on the neck was very characteristic of the ulcerative form of lupus vulgaris. Some of the nodules had evidently undergone atrophy, leaving cicatricial tissue behind.

DR. CUTLER said the case seemed to him unique in some respects. His own diagnosis was lupus vulgaris of a superficial character. The absence of ulceration, the extent of the lesion, the character of the nodules and the small amount of cicatricial tissue produced led him to think that possibly it was not lupus, but some other rare form of skin trouble. Hence he had presented the case for diagnosis.

**Case of Morphœa.**—Presented by DR. SHERWELL.

The speaker said he had already presented this patient at the 225th regular meeting of the Society (*Journal of Cutaneous and Genito-Urinary Diseases*, October, 1893). Since then he had removed a piece of the lesion on the neck and given it to Dr. Lustgarten for examination. The lesion is not increasing in size.

DR. LUSTGARTEN was not yet prepared to give his report of the histological examination. The specimen received from Dr. Sherwell was somewhat macerated and did not stain very well. The examination thus far has shown that there is no atrophy of the elastic fibres—if anything, hypertrophy—but there is considerable atrophy of the connective tissue.

DR. BRONSON said he is not inclined to regard the lesion in Dr. Sherwell's case as a mere atrophy. He did not think atrophy could produce so much thickening. The case came as near to true morphœa as any he has ever seen. While in London he saw a number of cases of morphœa col-

lected by Hutchinson at the Blackfriars Hospital, and it has always been a matter of surprise to him that we see the disease so rarely here. In a case of scleroderma of the arm in a young girl, presented to this Society, the scleroderma disappeared, leaving a sharply defined patch which seemed to be morphœa. The patch was perfectly white and remained distinct for some months, when the case was lost track of. In Dr. Sherwell's case the lesion seems to be the counterpart of that one. There is a lardaceous feel to it, different from simple atrophy.

DR. TAYLOR said that so far as the appearance of the lesion is concerned it is exactly like that in the case reported by him. In that case a careful histological examination was made by Dr. Van Giesen, who reported that the lesion, although it was elevated, was an atrophic process.

DR. BULKLEY said that if Dr. Sherwell's case is not one of morphœa the descriptions of that disease had better be revised. The hardness, the faintly violaceous border, the slight elevation (which he has observed in typical cases of morphœa), the absence of subjective symptoms, all point to morphœa.

DR. FOX said he agreed with Dr. Bulkley that from a clinical standpoint a more perfect picture of morphœa cannot be found. He stated that we may learn a good deal more than we now know about the atrophic or hypertrophic condition of the tissues in this disease, but he did not think we should apply different names to it. Change the definition of the disease, if necessary, but stick to the name that has been applied to it for so many years.

DR. PIFFARD said that in morphœa, as in a good many other conditions, there is hypertrophy in one stage and atrophy in another; for instance, as in certain affections of the liver or kidney.

DR. MORROW said he regarded the case as one of circumscribed scleroderma or morphœa. He agreed with Dr. Piffard that the atrophic condition is secondary to the hypertrophic.

DR. PIFFARD objected to Dr. Morrow's use of the expression "circumscribed scleroderma" as synonymous with morphœa. He considered that expression a frequent but utterly unjustifiable definition. He regarded scleroderma as distinct a disease from morphœa as measles is from small-pox.

DR. ELLIOT inquired upon what grounds the distinction was made? The same histological changes are found in both conditions, and he could see no reason why we should make anything more than a clinical distinction between circumscribed and diffused scleroderma. One patient coming under his observation presented over one hundred lesions; he had progressive muscular atrophy, from which he finally died. Each of the lesions began as an hypertrophy, perfectly lardaceous and indistinctly indurated, and went on to complete atrophy, so that there was nothing left but a thin skin.

DR. PIFFARD said that the confusion in the use of the two terms arose from the fact that certain dermatologists had found certain histological changes of the tissue in lesions to which they had seen fit to apply the name scleroderma, and other men had found the same changes in morphœa. In scleroderma there is a hide-bound condition. In a case he saw last year the scleroderma had developed over almost the entire chest. This case made a complete recovery in the course of a few months.

DR. SHERWELL said he regarded the case as one of morphœa. It does

not at present show that distinct areola which was apparent when the case was exhibited before. One clinical difference between scleroderma and morphœa is that in the latter the skin does not become adherent to the tissues below as it does in the former.

DR. BULKLEY said that in morphœa we can generally slide the skin very easily over the tissues beneath, while in scleroderma there is always a hide-bound condition.

**A Case for Diagnosis.**—Presented by DR. MORROW.

The patient, a woman, who but recently came under Dr. Morrow's observation, stated that she had been going to the New York Hospital for three or four years for the relief of an eruption which first appeared during the menopause. It is situated on both legs below the knees, and at first sight is suggestive of psoriasis. It has never, however, presented the scaly appearance of psoriasis and does not yield to the ordinary treatment of that affection. At one time it entirely disappeared temporarily under the administration of hydrastin muriate.

DR. BULKLEY said he had seen the woman a number of times during the past three or four years at the New York Hospital, and his diagnosis of her skin affection varied every few months as the processes changed under the different methods of treatment. Almost every known form of treatment had been tried. Occasionally the lesions would assume the serpiginous form; then again it would resemble lichen planus or psoriasis. He has never observed any weeping patches or anything which would suggest an eczematous condition. Proceeding on the view that the lesions were due to a dilatation of the blood-vessels, the woman was given hydrastin muriate (one per cent. solution), beginning with ten drops three times daily and increasing up to thirty or forty drops, and under the administration of this drug the lesions disappeared entirely excepting some slight straining. This drug, like ergot, exerts an action on the capillary blood-vessels, and it was the only remedy that ever produced the slightest improvement. In conclusion, Dr. Bulkley said he had no suggestion to make as to diagnosis; he regarded the case as entirely unique.

DR. ROBINSON said he saw a similar case at the New York Polyclinic that afternoon. Some of the lesions were of pinhead size, bright, scaly and with very slight oozing on injury, and others, somewhat larger, had very much the character of an ordinary psoriasis. The largest patches did not show as much scaling as we would expect in that disease. He had considered syphilis, lichen planus, eczema and psoriasis. It came closest to the cases of eczema seen in subjects with gout or rheumatism, and with sluggish circulation, generally found in the lower extremities, sometimes in the upper. There was some itching in the case he had seen, although not very much. He regarded the present case as an eczema to be cured by alkalies.

DR. FOX considered the case a very remarkable one, and after what he had heard about it he did not care to venture a positive diagnosis. He said that the lesions were more eczematous than psoriatic in appearance. He referred to the rebellious nature of the lesions, to the annular infiltration they presented, to their disappearance and return, and suggested that it might be a case of mycosis fungoides.

**Case of Multiple Chancres à Distance.**—Presented by DR. KLOTZ.

The patient was a young man upon whom the primary sores of syphilis



had simultaneously appeared on the lip and penis. He presented a well-developed chancre on the lower lip and another on the sulcus coronarius of the glans. The man also had now general syphilitic eruption.

DRS. MORROW and BULKLEY stated that such cases were comparatively rare, which was contradicted by Dr. Taylor.

DR. PIFFARD exhibited a tube containing a culture of trichophyton microsporon, made by Mr. B. H. Buxton, of the Loomis Laboratory, from the cultures sent by Dr. Sabouraud.

## THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY, DECEMBER 12, 1893.

DR. SAMUEL ALEXANDER, *Chairman*.

**Nævus of the Vulva with Ulceration.**—DR. C. W. ALLEN presented a patient, a female child aged seven weeks; she was brought to him on November 27th for an ulcer occupying the lower half of the right labium majus. The lesion was crater-shaped, with an uneven base, deeper in its central portion; a red margin surrounded its lower edge. On close inspection it was found that the seat of the ulceration was a congenital nævus. The ulcerative process so covered up the nævus that the diagnosis was not at all easy. Dr. Allen said that the possibility of ulceration in these vascular growths is well recognized. Three such instances have come under his observation.

DR. J. A. FORDYCE said he has never seen a nævus in this location. It is surprising that hemorrhage did not occur during the process of ulceration. He also mentioned the fact that these nævi sometimes disappear spontaneously without any ulcerative process.

**Case of Multiple Chancres.**—DR. F. TILDEN BROWN showed a case of syphilis with multiple initial lesions. One lesion occupies and has destroyed a considerable portion of the meatus, leaving a cup-shaped depression. The other two lesions are at the corona glans, one on each side. The patient first came under observation on November 16, 1893; he gave a history of having had irregular sexual connections. He now has glandular induration and a general roseola.

**Ciliated Infusion of Urine.**—DR. BROWN also presented some microscopical specimens of ciliated infusoria, and photographs of the same taken by Dr. Fordyce.

DR. BROWN also exhibited an apparatus facilitating the use of hot bichloride injections in the treatment of urethritis after the Brewer method. It consists of a zinc can capable of holding one quart of water, to which a rubber tube and Kiefer nozzle is attached. The apparatus is made by Daggett & Ramsdell, of this city.

DR. FORDYCE said he recently saw a case of syphilis in which there were five initial lesions; three of them were on one nipple and two on the other. The patient was a woman, and had become infected through nursing a syphilitic child obtained at an infant asylum. The child had mucous patches in the mouth.

**Some Unusual New Growths of the Vulva.**—DR. R. W. TAYLOR read a paper on this subject, and gave the histories of three such cases coming

under his observation, with photographs illustrating the same. The first patient was a female domestic of loose habits, who had suffered from chancreoids and suppurating buboes. No history of syphilis could be obtained after the most careful questioning, nor did a close examination of her body reveal any evidences of the disease. Subsequent to her thirty-fifth year she had suffered from vulvitis, which she ascribed to her former chancreoids. Intemperance and carelessness of person undoubtedly were largely contributing causes. When she was forty-five years old she entered Charity Hospital, and remained there until her death, which occurred nearly three years later. At the time of her entrance to the hospital the vulva was the seat of a maroon-colored flat new growth, which extended to the pubes and right inguinal region and encircled the anus. It began as a thickened, slightly elevated patch, of deep red color, upon the left small and large labia. From this region it extended by peripheral increase toward the vaginal orifice, over the clitoris and upward and downward on the right side, while on the left it jutted down to near the anal orifice. The increase in area took place slowly and as the new morbid tissue was formed, the older portions remained without any visible change, ulcerative or reparative. A slight amount of heat, pain and pruritus was felt at irregular intervals. The local symptoms, however, were for a long time so mild in character that the patient made little complaint. Dr. Taylor presented a photograph of the new growth taken two and a half years after the date of its beginning. From this it was seen that the normal appearances of the vulva were wholly lost. There were no traces of labia, large or small. The clitoris was represented by a central mass of cicatricial tissue, and the introitus vaginæ looks like a ragged slit. The perineum was also invaded. Extending from the vulva the disease invaded the pubes and the right groin, and also the skin of the fork of the thighs. In no place was there evidence of tumor-like formation, as the new growth was everywhere developed *en surface*. Its surface was maroon or chocolate colored, with considerable glossiness. At times this morbid surface was entirely dry, and at others it gave issue to a thin, scanty reddish serum. As the new growth extended it seemed to involve and infiltrate the whole thickness of the mucous membrane and the connective structures beneath them, and convert them into a firm, elastic tissue. Occasionally there was a tendency to healing in the juxta-genital parts above referred to; at no time could reparative changes be induced on or within the vulva proper. During its whole course, this new growth showed no tendency to luxuriate upon the surface. There was never any evidence whatever of ulceration. It never presented any appearance resembling papillomatous outgrowths. Though the process lasted many years, it did not seem to involve the contiguous lymphatic system. There was an entire absence of erythematous and erysipelatous complications. The disease showed no tendency to malignant degeneration, and of itself seemed to have no direct influence upon the general economy. The local symptoms were for a long time mild in character. Gradually, however, as the disease progressed without any abatement, the soreness in the parts was replaced by pain, particularly on the slightest movement. Walking became almost impossible, sitting became painful and the patient was forced to take to her bed. The swollen, contracted and excoriated condition of the vulvar sulcus impeded urination; the stenosis of the vaginal orifice prevented the use of cleansing and soothing injections, and impeded menstruation. In this the

patient was a pitiable object. Her sufferings, bed-ridden condition and worryment of mind led to utter demoralization, hopelessness, marasmus and death.

The second case narrated by Dr. Taylor closely resembled the first. There was no history of syphilis. The vulvar lesion, however, slowly healed under the application of mercurial ointment, although a previous thorough anti-syphilitic course of treatment by internal remedies had had no effect upon it. This patient entirely recovered.

In the third case, which also recovered, the lesion was tumor-like and wholly different in appearance and in its clinical history from the two previous cases. The microscopical examination of the lesions in these three cases was made by Dr. Ira Van Gieson, who reported that they were thoroughly identical. Dr. Taylor said the features of the first two cases might be mistaken for serpiginous chancroid, but close observation showed that the morbid process was essentially a hyperplasia and not an ulceration. He knew of no classical syphilitic process resembling it. Lupus is entirely different in its nature and course. Case III. might have been mistaken for hypertrophic vegetations, or even epithelioma, but the history and pathological appearances exclude these affections. No bacteriological studies were made in connection with the lesions.

#### The Requirements of a Suspensory Bandage, Including Remarks on its Uses and Abuses.<sup>1</sup>—By DR. E. FULLER.

DR. TAYLOR said that many years ago he adopted a modification of the jockey-strap, which is very satisfactory for hospital use. It simply consists of a triangular piece of muslin suitably plaited, so that it will not exert as much pressure as is produced by the ordinary jockey-strap. He first got the idea from a gymnast.

DR. F. J. LEVISEUR referred to the compressible suspensory bandage of Langlebert, also known as the Miliano suspensory, which is very much worn in Europe.

DR. BROWN said that some of the India-rubber suspensories that are advertised a great deal usually give rise to much torture on account of the pressure they exert.

DR. FULLER, in closing the discussion, said it is his impression that the very painful cases of epididymitis that do so well under considerable pressure are usually in tuberculous subjects. A number of such instances have come under his observation.

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## Selections.

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#### On the Erythème Induré des Scrofuleux of Bazin. T. COLCOTT FOX. (*British Jour. of Derm.*, Nos, 8 and 10, 1893.)

The first paper is devoted to a review of the literature of the subject, which is meagre enough, and a report of nine cases which have fallen under the author's observation. Of these, the diagnosis in two or three, as he says himself, is not beyond dispute.

<sup>1</sup> See page 45.

The second article, in the October number, contains the gist of the subject. The diagnostic points are as follows: the lesions are nodular in character; they are situated in the subcutaneous tissue and may continue deep-seated for a considerable time without projecting the skin covering them; at some time, however, they do involve the superficial layers, the skin acquires a reddish hue which afterward becomes violaceous. Approximately, the lesions are pea or hazel-nut sized, being smaller on the fingers. Their course is indolent; they terminate by involution, complete or partial, by suppuration or necrosis *en masse*. In the last case, a punched-out ulcer results like that of a syphilitic gumma. The nodules are generally discrete, limited to six or ten on a leg and the lower parts of the legs, especially the back and outer parts, are most involved, though these characteristics do not always obtain. They are usually painless, except after long standing. The limbs, and particularly the lower, seem the only parts involved. The average age of the patients is between twelve and seventeen. They are undoubtedly below the standard of health, but a tuberculous or syphilitic history, family or personal, is not remarkable for its frequency. Their circulation is usually poor and considerable doughy œdema is not uncommon. The disease attacks chiefly young women who stand long at their work.

The nature of the lesions Fox does not discuss, but he is evidently little inclined to the theory that they are tubercular. They must be differentiated from erythema nodosum, from phlebitis and thrombosis, from tuberculous and syphilitic gummata. The diagnosis in the last two cases is difficult. They are distinguished from tubercular lesions by the fact that the latter usually form abscesses, are met with at an earlier age, attain larger size, are less numerous and a history of tuberculosis is usually present. The distinction is even more difficult in syphilis. There is hardly a point which is free from doubt and the only possible method is to take the whole group of symptoms into consideration. The therapeutic test fails because the patients, in hospital, improve under anti-syphilitics.

Rest in the horizontal position and well-applied, methodical compression are the best agents at our command for the relief of the condition. Rubber bandages and resolvent applications irritate unless watched.

J. C. JOHNSTON.

#### Two Cases of Unusual Location of Chronic Blennorrhœa in Women. FIN-GER. (*Wien. Med. Wochen.* Nos. 32, 33, 1893.)

According to the author, these cases are the first published in which the chronic blennorrhœa was confined to the urethra, the external and internal organs being at the same time healthy. The symptoms of chronic gonorrhœa in women are objective purely, and in these instances could be seen only when the patients had not passed water for several hours. Stripping the urethra from behind forward, milky mucous-like pus could be squeezed out and the urine, passed after thorough cleansing of the external genitals, was turbid or contained gonorrhœal threads.

#### The Value of Microscopical Examination for Gonococci. NEISSER. (*Deut. Med. Wochenschrift.* Nos. 29, 30, 1893.)

Neisser recommends the examination of pus for gonococci, for the following reasons:

1. It is beyond doubt that gonococci are the true cause of gonorrhœa.



2. In many cases, especially in chronic affections, with only slight subjective and objective symptom, the proof of the existence of gonococci leads us to a correct diagnosis and thereby to an effective treatment (instead of using inefficacious astringents we apply well-known anti-blennorrhagics, such as silver, mercurial salts, ichthyol, etc.).

3. In cases where the question arises whether gonorrhœal disease is the result of infection or is the remnant of a previous outbreak, examination for gonococci is indispensable.

4. Since in every stage we must adjust our treatment to the number of gonococci present, the search for them is necessary not only in the beginning but during the whole time of treatment.

5. In the present state of our knowledge, examination for the germs must be confined to the microscopical ; bacteriological cultivation is too troublesome.

6. Where we receive positive proofs of the presence of gonococci the diagnosis is made. In negative cases caution is necessary as it is well known that the bacteria may exist in the deeper structures, lacunæ and mucous folds in such small number that the superficial secretions under examination may be entirely free. Then it becomes imperative to excite artificial irritation to increase the number and bring them to the surface. Clinical symptoms will aid considerably in this condition.

7. In married persons the existence of gonorrhœa in one will impose on us the duty of treating the other.

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## Book Reviews.

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*Report of the Leprosy Commission in India*, p. 456. Published for the Executive Committee, by William Clowes & Sons. 13 Charing Cross, S. W., London, 1893. Price five shillings.

The Indian Leprosy Commission was appointed by the National Leprosy Fund, as a fitting tribute to Father Damien and as the best means of perpetuating the memory of his martyrdom. It was agreed that the Commissioners should preferably devote themselves to the study of the ætiological features of leprosy, and should for this purpose travel from center to center, from asylum to asylum and personally inquire into the histories of as large a number of lepers as possible. They were to employ thus the five months of cold weather and subsequently to assemble at some hill station and supplement their inquiries by pathological and bacteriological researches.

As a result of these instructions two thousand lepers were examined by the Commissioners with regard to heredity, contagion and other ætiological factors, such as food, syphilis and defective hygiene. The relation of leprosy to soil, climate, race, etc., were minutely considered.

The Commissioners in preparing their report have, as they state, been only guided by the facts obtained by themselves (p. 266) as "it would be useless in an inquiry of this nature to take the word of the native inhabitants," (p. 265) or "would it be permissible to be too much guided by the opinion of medical observers in India. The leper not really being such an outcast or deplorable individual as European opinion considers him to be,

is seldom seen in the dispensaries, and most civil surgeons therefore have not much opportunity of studying the ætiology of this disease" (p. 266). This statement seems hardly justifiable, inasmuch as the Commissioners on every occasion put the civil surgeons as well as the military under contribution, not only in assembling the lepers of the districts visited, but also in furnishing them all needful information.

The data, as collected and presented by the Commissioners concerning the cause and spread of leprosy seems purely of a negative character. While they admit that the existence of Hansen's bacillus proves the infective nature of the disease, and that experimental research shows that it must be classed among the contagious diseases, they at the same time deduce as the result of their investigation eight arguments against the spread of leprosy by contagion, including therein the vital questions of inoculation and vaccination. Moreover, the Commissioners, while affirming repeatedly that leprosy is not on the increase in India, and by reason of its restricted influence cannot be considered as an imperial evil, fail to explain its continued existence in the admitted absence of any direct causal effect of hereditary contagion, soil, climate, food, etc. They prefer to consider that "leprosy in the great majority of cases originates *de novo*." The Special Committee very naturally objects to this spontaneous creation theory. In pursuance of their belief in the innocuity of the leper, the Commissioners do not recommend his enforced segregation, nor an interdiction of marriages with lepers. These conclusions are not in harmony with the opinions of the Special Committee, and absolutely at war with the consensus of opinion of the countries where with smaller populations, greater accuracy of observation is possible, and where in many cases leprosy has been for the entire country in reality a *de novo* growth, and hence its invasion and progress could be studied both in the individual case and in the aggregate.

The Commissioners have had, in general, a curious way of eliminating from their cognizance all statements contrary to the maintenance of their own personal theories. They conceive the chain of reasoning of such men as Gairdner, Arning, the West Indian doctors, to be defective, inasmuch as concomitant events do not eliminate other factors than those accepted by the latter as causal to the propagation of leprosy, vaccination and accidental inoculation. The Commissioners' own statements upon vaccination and its affirmed innocuity are largely derived from Dr. Pringle's paper upon the subject. The latter's conclusions are, as well known, opposed to those of the generality of physicians throughout the world. The paragraph of the report which more particularly bears upon the subject (p. 268) is assertive without being demonstrative, and its fifth or last heading contains the power of entailing a false security about the inoffensiveness of an indiscriminate vaccination which might well lead to an outbreak of leprosy similar to the one in the Sandwich Islands. The Special Committee do not, therefore, concur with the Commissioners in their opinion "that the extent to which leprosy is propagated by contagion and inoculation is exceedingly small." (p. 345.)

The therapeutical considerations are derived from other reports and works on leprosy, and contain nothing personal to the Commissioners. The Appendix contains the laboratory report of the work done by the Doctors Rake, Buckmaster and Surgeon-Major Thomson at Almore and Simla.

E. N. B.-B.

*A Practical Treatise on Diseases of the Skin*. Third Edition, Revised and Enlarged. By JAMES NEVINS HYDE, A.M., M.D. Lea Brothers & Co., Philadelphia, 1893.

Succeeding editions of a work are variously interesting, not only for the proof of its usefulness and the consequent demand for it, but for the fact that they are the milestones by which measure can be taken of the advance along the path of progress. It is doubtful if the advance has been anywhere in the field of medicine so rapid as in dermatology and the assurance of it lies here before us. The last edition of Hyde's book appeared in 1888, and since that time the investigations carried on and chronicled in almost every civilized land, have compelled the consideration of thirty-five new diseases, have added a needed correction to nearly every page, have relegated more than one disease to the shades of oblivion and established others on a surer basis. Lupus vulgaris, of course, finds its place now among the tuberculoses and modern bacteriology, in rewriting the chapter on tuberculosis cutis, he has added the verrucous and orificial varieties, together with the several dermatoses of the scrofulous. This is but one example of the many changes found necessary.

The more important new chapters are those on Xanthoma Diabeticorum, Pityriasis Rubra Pilaris, Keratosis Follicularis, Leucokeratosis Buccalis, Pemphigus Vegetans and various forms of parasitic eczema. One naturally turns with some curiosity to see what position every writer will take on the much-vexed question of the parasitic origin of these eczemas. While Hyde accepts the trichophyton as the cause of eczema marginatum and describes Unna's eczema seborrhoicum (deploring the name, however), thereby declaring his belief in its fungoid genesis, it is disappointing that he does not enter the discussion. He contents himself with putting forward merely the bare statements of his colleagues and the same is the case with xanthoma diabeticorum and the exfoliative dermatitis. Among the minor articles which he treats for the first time are Erythema Scarlatiniforme, Epidemic Exfoliative Dermatitis, Angioneurotic Oedema, Acromegaly, and several of the lately described gangrenes of the skin. It is unfortunate, in a way, that this work is intended as a guide, for besides preventing discussion where discussion is needed, it leads the author to begin his articles with a definition. If the total inadequacy of a definition to describe a cutaneous disorder were never before apparent, it is here. The classification of the American Dermatological Association is still adhered to as best adapted to the authors' ideas of the needs of students and practitioners, but, for convenience, the diseases due the invasion of bacteria he groups under one head.

Treatment and prognosis are essentially modified and many useful hints have been incorporated in the first, particularly in the methods of administration and of application of remedies. All the formulæ given are written both in grains and grammes and are noticeably and commendably few in a book intended "for students and practitioners." Bibliography is necessarily limited by the scope of the work, the references being generally restricted to a few articles of special interest in connection with each chapter. References to other volumes simply by personal mention are by no means so confined.

Hyde recognizes the need, in a work on dermatology, of illustration, by the addition of five plates and more than twenty wood-cuts, taken as a rule from his own patients and creditably done, though the reader will recognize more than one familiar friend among the older pictures.

J. C. J.

*The Treatment of Constitutional Syphilis.* By O. ZIEMSEN, M.D. London : H. K. Lewis, 1893.

The work of this author, as published in 1878 and again in 1891, is well known. The book now before us seems to be a translation of the last German edition, although no hint of such a thing is contained between its covers. It is a plea for the long-continued and thorough treatment of syphilis by a non-specialist and by the use of mercury and of iodide of potassium combined with thermal waters both by the mouth and by baths. The author places most faith in mercurial inunctions, and regards the treatment by hypodermic medication as "unsuitable for the radical cure of syphilis." The brochure is pleasant to read, but not as the Germans say, "an epoch-making" book.

G. T. J.

*La Pratique Dermatologique et Syphiligraphique des Hôpitaux de Paris.* Par P. LEFERT. Paris: Baillière et Fils.

This little book contains a large number of prescriptions and short accounts of the treatments used by the principal dermatologists and syphilographers of the Paris hospitals. Such books are of doubtful value.

G. T. J.

*Traité des Maladies des Voies Urinaires.* (Treatise on Diseases of the Urinary Passages). H. PICARD. J. B. Baillière et Fils, Paris, 1893.

The author's object in presenting this volume, as he himself states in his preface, is to put forward in as simple a form as possible, modern ideas in regard to the treatment of these maladies. His attention is confined chiefly to the treatment. Beyond a plain statement of facts as regards etiology and symptomatology he does not go, and he seems rather inclined to ignore morbid anatomy altogether, but his lines of treatment leave little to be asked. He omits description of operative procedures such as, for example, when he mentions lithotomy, nephrectomy, external and internal urethrotomy while he devotes pages to the treatment of causes leading to the necessity for these operative procedures. He says : "It is of the highest importance to understand the treatment capable of preventing them (calculi), and in every case, their first symptoms, the gravity of the operations which they demand, increasing with their diameter." This is the keynote of the volume, and as the science of medicine becomes more and more preventive it will be the more appreciated. Picard is a firm believer in hydrotherapy and his comments on useful mineral waters, unfortunately almost confined to the French and German, are very complete. He begins with the urethral affections, their complications in men and women, then follows tuberculosis, prostatic hypertrophy, "urinary sclerosis" and calculi. His chapter on cystitis is deserving of the highest commendation and is probably his best work. The sixth chapter is devoted to the symptoms common to many of the urinary diseases, their diagnosis and treatment. He includes in his work spermatorrhœa and impotence, catheterism fills an entire chapter, and the volume is concluded by a thorough exposition of the latest investigation as to treatment in diabetes. The order adopted enables him to show with great clearness the intimate relationship between morbid conditions in different portions of the urinary tract. His dietary lists are well worth careful study.

J. C. J.



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## Original Communications.

HYDROA VACCINIFORME, BAZIN; HUTCHINSON'S SUMMER ERUPTION; WITH HISTOLOGICAL EXAMINATION.

BY

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A CONSIDERABLE number of cases of hydroa vaccini-forme are now on record, of late mostly from English, German and Norwegian sources. No instance of the disease has been reported in America, however, so far as I am aware, and no histological examinations of excised lesions are anywhere recorded. For these reasons, if apology is necessary, the following case is reported.

J. G., ten years of age, male, came with his father to the skin department of the Massachusetts General Hospital on August 30, 1893, from Lawrence, Mass., his native place. Father is an American, mother Scotch; both healthy, and no family history of importance could be elicited. Patient is an only child. The only other diseases that he has had are measles and typhoid fever. The present affection first showed itself at five years of age, during the Summer, when the boy was out of doors in the fields and woods a large portion of the time. Since then the affection has recurred constantly in successive outbreaks, mostly during the summer months and always *after exposure to the sun*. In Winter there have usually been a few mild attacks, and the father thinks that he has never been entirely free for a longer period than two months at a time. The outbreaks were confined to the face until one year ago, when

similar appearances were noted on the hands ; but on the latter there have not been in all more than two dozen lesions. At the beginning of some of the attacks there have been nausea, vomiting and malaise, but not in all. There has always been considerable itching of the affected parts. Of late the attacks have appeared rather less frequently, and there has not been so much fluid in the lesions. The appetite and general health are said to be good.

The patient when seen presented the appearance of a rather undersized, pale and anæmic boy, of distinctly light complexion. The face is covered with closely aggregated and confluent pits, of exactly the contour and general appearance of those left by variola, and the boy has repeatedly been asked by strangers when he had small-pox. The deepest scars and most confluent pits are upon the nose and malar prominences, so that the nose appears attenuated. The forehead is but slightly pitted, the scars diminishing in number and depth toward the edge of the hairy scalp, where they cease entirely. The ears are covered with cicatricial depressions, especially marked upon the helix. (Fig. 1.)

The active lesions consist first of small red papules and vesicles, of which a number are now to be seen, and which the father, an intelligent man, declares to be the primary manifestation. The minute papule rapidly becomes vesicular, and vesiculo-pustular, and of these there are a large number scattered over the face and ears. The lesions may progress no farther than this, or they may enlarge still more until those of the largest size represent rounded, vesicular elevations with a distinct and sometimes very marked *umbilication* in the center. The umbilicated center is surrounded by a ring of clear or turbid fluid, while the periphery is occupied by an erythematous halo. All of the vesicles are not umbilicated, but only, as a rule, those furthest advanced. The center presents, besides the umbilication, a peculiar *dark blue or black* aspect, which can be seen on close examination to be due to the floor of the lesion, and not to the contents of the vesicle. In many of the lesions this dark floor contains several *distinct points of a deeper hue* than the rest. These vesicular and pustular lesions may become confluent, as is seen prominently upon the ears.

The next stage, which is also represented on this patient, consists in the crusting of the vesicular center. The dark blue or black center, with its vesicular covering, gives place to a thick black crust, which is very adherent, and, when finally

thrown off, leaves a deep, usually circular, "punched out" pit, which is at first of a deep red color. In several instances new lesions could be seen forming within an old pit or scar. There was no pigmentation. The hands show upon their dorsal sur-



FIG. 1.

faces a dozen or fifteen pits upon each, with one or two small vesicular lesions. These appearances do not extend above the wrists, and there has never been a lesion upon any other part of the body than the face and hands. The cervical and submaxil-

lary glands are considerably enlarged, as are also the inguinal. The other glands are normal. There are no lesions or abnormal appearances upon the mucous membranes.

On October 27th the patient was seen again. The lesions had disappeared more quickly than usual under the use of a carbolyzed lotion containing oxide of zinc and iron internally. There was then a short period of respite, until two weeks ago, when another attack began. The ears are now much swollen and covered with large, confluent, umbilicated vesicles, with the characteristic dark center. The same appearances are on the face, although fewer than when last seen. A well-developed vesicular lesion, with the characteristic dark appearance of the center, as seen through the vesicular covering, was removed from the helix of the ear for microscopical examination.

A third outbreak was seen on December 13th, similar to those already described, but somewhat more intense. It had come on immediately after going out of doors on a sunny, but exceptionally cold day, and according to the father the whole face had at the outset been much swollen.

The patient was last seen in the first week of February, 1894. The lesions seen on December 13th disappeared soon afterward, leaving the customary pits, but a few weeks ago there had been another mild outbreak which was still to be seen. A few small, primary vesicular lesions without central discoloration were present, one of which was excised for microscopical study. The patient had been using by advice an ointment colored black by lampblack, but this appears to have had no influence on the recurrence of the lesions. It was impossible, however, to determine how faithfully this procedure had been carried out. The disfigurement of the application made it naturally unpopular.

This disease was described many years ago by Bazin<sup>1</sup> under the name *hydroa vacciniiforme*. Of late years it seems not to have been seen by the French. At least, I can find nothing that corresponds to it in their writings, and Bazin's description is dismissed by Brocq<sup>2</sup> with the remark that it does not seem to correspond to any of the dermatoses actually classified. Hutchinson<sup>3</sup> in 1888 described the same affection under the title of "Summer eruption," while Handford<sup>4</sup> in an excellent article

<sup>1</sup> Cours de Semiotique Cutanée, 1855.

<sup>2</sup> Traitement des Maladies de la Peau, 1892, p. 347.

<sup>3</sup> Clinical Society's Transactions. Vol. xxli.

<sup>4</sup> Illustrated Med. News, 1889.



in the *Illustrated Medical News*, with colored illustration, showed that Hutchinson's cases and his own were the same as those described by Bazin as *Hydroa vacciniforme*. Since then cases have been reported by Jamieson,<sup>1</sup> Berliner,<sup>2</sup> Buri,<sup>3</sup> Broes van Dort,<sup>4</sup> Brooke<sup>5</sup> and Boeck.<sup>6</sup> H. Radcliffe-Crocker in the last edition of his text-book gives a very good description of the disease, adding that he has seen two cases himself.

A brief résumé of the important clinical features may not be out of place here. The disease begins, as a rule, in the first years of life, and is far more frequent in the male sex. It is excited by exposure to the sun and affects consequently the uncovered parts of the body almost exclusively, although Bazin notes its occurrence on the covered portions also. The bridge of the nose, cheeks and ears are prominently affected as well as the backs of the hands. In some cases the legs, when exposed, have been affected, but in my own case, although the boy frequently went barefoot in Summer, it had never appeared except on face and hands. The disease occurs in attacks, usually in the Summer season, the patients being comparatively free in Winter. My patient seems to have had more attacks in Winter than had occurred in the cases previously reported. Another peculiarity of my case is that the itching was quite a pronounced feature. As a rule there is no itching. The eruption may be accompanied at the outset by a slight constitutional disturbance, and begins either as vesicles or as small red elevations, which develop rapidly into vesicles and bullæ, and frequently become confluent. Many of these vesicular lesions become depressed in the center and resemble a vaccination vesicle. Around the umbilicated center there is often a ring of fluid, and a red areola surrounds the whole lesion. The center has a dark blue or black aspect, owing, as will be seen, to the necrotic and hæmorrhagic corium seen through the overlying vesicle. Some of the lesions may become purulent. The necrotic center becomes converted into a thick black crust, which is with difficulty detached, and when it finally falls off leaves a deep permanent scar almost exactly like that left by variola. The attacks last as a rule several weeks. They seem to become milder toward puberty, and to cease in adult age.

<sup>1</sup> Lancet, 18 August, 1889.

<sup>2</sup> Monatsheft, f. prakt. Derm. Bd. xi., 1890.

<sup>3</sup> Monatsheft, f. prakt. Derm. Bd. xiii., p. 181.

<sup>4</sup> Monatsheft, f. prakt. Derm., March, 1892.

<sup>5</sup> British Journal of Derm. Vol. iv., 1892.

<sup>6</sup> Archiv. f. Derm. und Syph., 1894, p. 23.

*Histological Examination.*

The well-developed lesion from the ear, which showed the characteristic dark appearance of the center, was hardened in absolute alcohol, imbedded in paraffine and cut in serial sections.

*A necrosis of the central portion of the nodule* proved, as was to be expected, the salient feature. The sections from the middle of the lesion, representing the most advanced stage of the process, showed, upon staining with various reagents—hæmatoxylin and eosine, Orth's carmine, safranin, etc.—a central portion consisting of both corium and epidermis, where the normal connective tissue and epithelial cells had nearly or quite lost their susceptibility to staining.

The outer horny layer was found to be unbroken and more or less distinctly stained by safranin or carmine. The lower layers of stratum corneum, together with the entire rete, were completely necrotic, giving no reaction to ordinary staining fluids, with the exception of an imperfect nuclear staining here and there. The middle and lower layers of the rete were converted into a reticular tissue, forming a network filled with granular detritus and an occasional leucocyte. This network was everywhere necrotic. At the border of the rete and corium the network ceases. The necrosis, however, extends downward beneath the vesicle through the entire corium, ceasing only a short distance above the subcutaneous tissue. The depth to which this necrosis extends is particularly striking. The corium throughout the affected area retains few of its normal appearances. The connective tissue cells have in great part lost their power of reacting to staining fluids. The fibres are broken up and forced apart and contain in their interstices an abundance of various-sized granules and detritus which are prominently brought out by staining with safranin. In the region of the papillary layer, enlarged necrotic blood-vessels filled with blood cells are seen in many of the sections, and often in the vicinity of these vessels a free hæmorrhage into the necrotic tissue is apparent. In many of the sections, especially in those corresponding to the center of the lesion, a hair follicle may be seen, as shown in the figure, which has participated in the general necrosis.

The necrosis ceases quite abruptly at the sides and also at the base of the lesion. The epidermis adjacent to the necrotic portion is slightly increased in thickness and is otherwise nor-

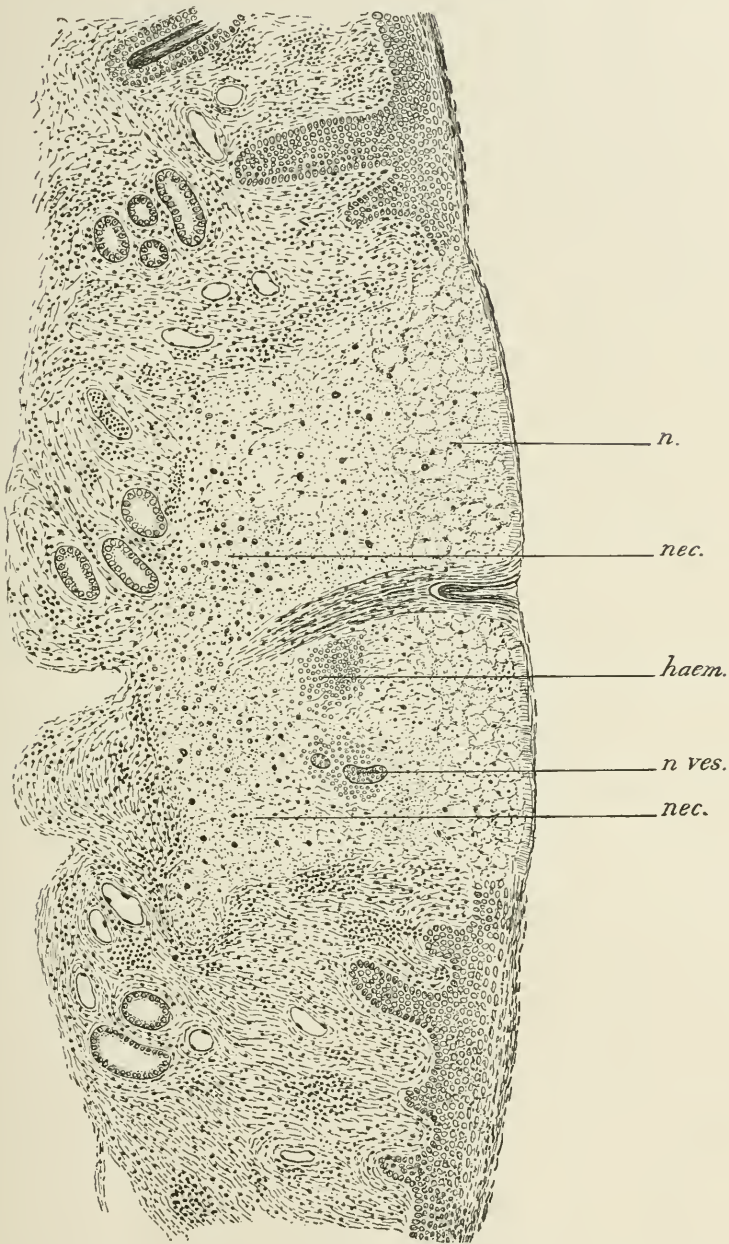


FIG. 2.

*n.*, network in the epidermis. *nec.*, necrosis in the corium. *haem.*, hæmorrhage in the connective tissue. *n. ves.*, necrotic vessel filled with blood globules.

mal. The corium is filled with small round cells for a considerable distance from the necrotic portion, but no signs of necrosis are visible here. The hair follicles and sweat glands in this area are normal and rather numerous.

Staining by the various methods for the detection of microorganisms, revealed nothing that could be regarded as important from an etiological standpoint. In several sections examined a few clumps of micrococci were stained, but they were not constant.

In order to determine, if possible, the starting point of the process, a small primary vesicle, that had just appeared, and in which there were no dark appearances in the center, was removed from the face, hardened in alcohol, imbedded in paraffine, and cut in serial sections. The histological appearances were those of a vesicle situated in the middle layers of the rete. There was some reticulation of the upper portion of the rete, but the fluid had pressed apart the middle from the lower layers, giving rise to a large chamber, without signs of a network. The lower rete cells below the vesicle were intact, except for the presence of some round-celled infiltration. No evidence of necrosis was anywhere seen. In the corium a considerable round-celled infiltration, especially about the blood-vessels, was the only abnormal feature detected.

So far as can be determined from these two lesions, representing the primary and more advanced stages of the process, the disease begins with an inflammation in the epidermis and upper part of the corium in circumscribed areas of the skin, and speedily results in the formation of a vesicle in the rete. In those lesions that do not end with this stage the epidermis and underlying corium to a considerable depth become rapidly necrotic, the necrotic corium, with its dilated and necrotic blood-vessels and hæmorrhagic foci, showing through the vesicular epidermis, and giving rise to the dark red center seen in the well-developed lesion, and to the dark red and violet points that have been described. The lesions may become quite large by confluence or by extension. After a few days they show a depressed center, which rapidly dries up, and a closely adherent crust is formed, which after another regular lapse of time is cast off, leaving a variola-like pit.

Such appears to be the pathological course of these lesions. But the description gives no explanation of the circumscribed necrosis thus produced by the sun's rays, and an analogy with any other known dermatosis is searched for with difficulty.



The affection has most similarity with the *acne necrotica* of Boeck,<sup>1</sup> a disease whose relationship to *acne varioliformis* has not been definitely settled. Pick<sup>2</sup> considers them distinct affections, and describes a case of each; the second of his cases, which he considers Boeck's *acne necrotica*, certainly corresponds pretty accurately in description with *hydroa vacciniforme*. Tonton<sup>3</sup> reported at the German Dermatological Congress in 1891 a case of *acne necrotica* with histological examination, in which the microscopic appearances have many points of resemblance with those of *hydroa vacciniforme*. The marked vesicular appearances of the latter are absent in *acne necrotica*, but there is the same circumscribed necrosis, umbilication, and enlargement of papillary blood-vessels with hæmorrhage. Bronson and Fordyce<sup>4</sup> have also reported a case of *acne varioliformis* of the extremities in which Fordyce's microscopic examination offers many points of analogy with *hydroa vacciniforme*. The relationship of these three affections, if any, I shall not attempt to indicate. They have at least the common feature of a circumscribed necrosis followed by variola-like pits, and may be studied side by side with advantage.

The studies of Weigert<sup>5</sup> in variola indicated that, contrary to the general belief, the necrosis was the primary result of the small-pox poison, and that the inflammatory appearances, which determine so largely the characteristics of the papule or pustule, were secondary phenomena. A large number of observations convinced him that in every lesion of variola a necrosis of the lower rete cells can be found by diligent search, although in the earliest papules it may be present in only one or two sections from the center. Hence his theory that the poison attacks and destroys the lower rete cells as the first pathological change. The early lesion in this case of *hydroa vacciniforme*, was therefore carefully examined for the necrosis, to determine if the sun's rays by their chemical action might cause a primary necrosis of the rete in the same way as do the organisms (?) in variola. But no necrotic cells were found in this early stage, the appearances being simply inflammatory, so that, so far as can be concluded from the examination of a single lesion, the inflammation in corium and epidermis is primary, the necrosis a secondary phenomena.

<sup>1</sup> Archiv. f. Derm. u. Syph., 1889, p. 37.

<sup>2</sup> Archiv. f. Derm. u. Syph., 1889, p. 551.

<sup>3</sup> Archiv. f. Derm. u. Syph., 1892, *Ergänzungsheft*, p. 287.

<sup>4</sup> JOURN. OF CUTAN. AND GEN. URIN. Dis., April, 1891.

<sup>5</sup> Lehre von den Pocken. Breslau, 1874.

Weigert came to the conclusion that the umbilication of the pustule was due to the necrotic masses in the rete, which held down the center of the lesion firmly, while the epidermic cells at the sides proliferated and formed a raised wall. Somewhat the same explanation may be offered for the umbilication of the lesions of hydroa vacciniiforme. We have here, as in variola, a necrotic center with fluid exudation, and it is probable that these necrotic cells binding down the upper covering are the cause of the umbilication. There was not a decided epithelial proliferation found at the periphery of these lesions, as Weigert considers necessary for the formation of the umbilication in variola, yet there was a slight increase in thickness of the epidermis. It may be doubted whether this epithelial proliferation is an essential factor in umbilication. But the necrosis seems to play a prominent part, as it is only in lesions in which there is a central necrosis that we see umbilication, as in variola, vaccinia, acne necrotica, probably varicella, etc.

Of late years attention has been directed to the action of the *chemical* rays of the sunlight as the cause of eczema solare, sunburn, etc., in cases where there was great sensitiveness to the sun's rays, while intense heat from other sources caused no symptoms. Hutchinson has described numerous cases of recurrent papular, pruriginous and eczematous eruptions which occur chiefly on the exposed parts of the body during the Summer months. The relation of these various conditions to hydroa vacciniiforme should be more carefully studied, but it seemed to be already proved that the sun's rays may cause not only superficial inflammatory cutaneous changes, but in certain individuals a deep, sharply bounded destruction of tissue.

The treatment of the affection has not been especially successful. Almost any protective covering in the form of paste or ointment will probably be of service. Veils of red and turmeric,<sup>1</sup> colors which are supposed to neutralize the ultra-violet or chemical rays are recommended, and have been of value in eczema solare.

<sup>1</sup> Unna. Monatsheft, f. Prakt. Derm., 1885.

THE PRINCIPLES OF ANTISEPSIS IN THE TREATMENT OF ECZEMA.<sup>1</sup>

BY

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EVER since Joseph Lister put to a practical test the results of the investigations of Pasteur and others, and began to teach the surgeons that wounds could and must be protected against the invasion of the agencies of septic infection, the entire field of medical science has been permeated by the doctrine of antisepsis, and every branch has recognized the importance of its principles. In ophthalmology and otology in laryngology, in obstetrics and gynecology and andrology therapeutics have been more or less transformed under this influence, and wherever it was possible to extend the protecting agencies they have been applied. Even in the treatment of internal organs, efforts, though not always successful, have been made to imitate the surgeons or to apply surgical measures. But in dermatology, although the object of its study and its therapeutic actions, the outer integument of the human body is constantly and in its entirety exposed to all the dangers of microbic infection, comparatively little has been written or said of antisepsis. It is true, if we look over the list of remedies generally employed in the treatment of diseases of the skin, we shall find a large number of drugs the action of which is decidedly an antiseptic one, be it that they have been introduced or discovered only since the antiseptic era, on this very account, be it that they had been in use long before, and only on later investigation were found to have antiseptic properties. If thus the dermatologists are actually applying antiseptic treatment, it is apparently often done unconsciously and unintentionally, without a proof that they realize the presence of conditions which require antiseptic measures, and without either a clear understanding of the meaning of their therapeutic action itself or the distinct expression of their intentions. Still, I believe that a certain lack of pronounced general principles in treatment is one of the obstacles to simplification of dermatological therapeutics and one of the causes favoring the publication in the medical journals of the numerous, "useful" formulæ for prescriptions against skin diseases. This can be said with

<sup>1</sup> Read before the 229th Meeting of the N. Y. Dermatological Society.

particular force of eczema, the most important and most frequent among the diseases of the skin, although I want to acknowledge that I found, much to my encouragement, that Dr. R. Crocker, in the second edition of his book on "Diseases of the Skin," has given due prominence to the antiseptic properties of some of the remedies in common use against eczema and has pointed out their actual effects much more distinctly than is generally done in the hand and text-books. It therefore seemed to be of sufficient interest to briefly consider the conditions in eczema which invite or require the application of antiseptic principles, to inquire into the reasons why this application has not been made in practice and to define the best methods for the same.

In approaching the first of these questions, the much-debated etiology of eczema can be entirely left out of consideration ; it does not make the slightest difference for our position whether eczema is always or in a number of cases a parasitic disease, or whether it owes its origin to nervous or trophic influences or only to external irritation. Among the various opinions prevailing among different schools in regard to its causes it is almost universally acknowledged that, anatomically, eczema is a catarrh, a superficial inflammation of the skin, not extending deeper than into the papillary stratum of the cutis proper. In the majority of cases the corneous layers of the epidermis become detached from the rete malpighi by a serous exudation either in the shape of vesicles or over a larger and more irregularly defined surface (ecz. madidans). In either instance the thin cover is more or less rapidly carried off by mechanical means and the reddened, moist rete is largely exposed. Experience teaches that the intact corneous layer of the epidermis furnishes ample protection against the entrance through the skin of pathogenic microbes into the lymph and blood circulation, but that the slightest break in its continuity opens a door to infection, not only with the virulent elements of suppuration and sepsis, but also with those of syphilis, tuberculosis, etc. It is evident, then, that the conditions in eczema referred to above afford the most favorable opportunity for the many microbes with which our atmosphere is charged, the more so the more we are surrounded by the blessings of civilization, to settle down, grow on the serous secretion, which furnishes a splendid culture medium, to enter the lymph channels and through them the blood-vessels, causing local or general blood poisoning. In fact, it has been shown that microbes, pathogenic and appar-



ently non-pathogenic, are constantly found in large numbers and varieties on the skin, so that it seems almost impossible that a portion of the surface deprived of the cover of the epidermis would remain uninfected even for a moment. The formation of crusts by the drying up of the secretions over some parts or over the entire denuded surface largely increases the danger by giving a certain protection to the growing and multiplying microbes against external injury, and favors the resorption of poisonous substances. In other cases the contents of the vesicles rapidly become purulent, even before they break down, or the secretion from the entire surface becomes purulent. Instead of the thin, paper-like crusts, which are formed by the serous discharge, yellowish or brown crusts cover the surface, particularly where the presence of hair favors the undisturbed drying of the secretions. It is quite irrelevant for our purposes whether suppuration is considered an essential feature of eczema, whether the pustules of impetiginous eczema are included in the eczematous process or whether we consider suppuration as a secondary infection. With our present knowledge we must assume either way that an infection with pus-forming microbes has taken place, that conditions similar to those of a suppurating wound or of a suppurating mucous membrane are present. I am myself inclined to believe, with *Pick* (*Prager Med. Wochenschriften*, 1883, p. 13) that suppuration, the so-called stage of eczema impetiginosum, makes its appearance only when local septic infection complicates the moist stage. Where such an event does not take place the vesicular, or moist eczema, passes immediately into the squamous stage." Where the exudation on the surface is not present, or in so moderate a degree that no moist surface is presented (eczema erythematosum, papulosum et squamosum), the excoriations resulting from scratching afford an equally commodious entrance to all kind of septic material, and in their turn often actually become the seat of more or less deeply seated suppuration. Besides, in squamous eczema often closer inspection and a slight effort to remove the scales will reveal the presence of smaller or more extended surfaces, the scales preventing the oozing out of the secretion and greatly favoring the absorption of septic substances into the lymph system. In other cases, with more extensive infiltration of the cutis and considerable accumulation of horny scales, the formation of cracks or rhagades will represent another condition apt to become the seat of septic and other infections and for the formation of

ulcers simple or specific. I want to call particular attention to the eczema occurring in connection with pediculi capitis. This, as a rule, is an impetiginous one, likely to spread along the neck, around the ears, into the face, sometimes on the hands, in the shape of numerous small pustules, the result of contamination by the finger nails of the patient, which become infected by scratching.

Now, whoever once has become imbued with antiseptic principles will not only see the danger, but will at the same time be impressed with the necessity and the importance of the immediate disinfection of the infected parts and of further protection against new infection. As long as suppuration exists a cure is apparently out of the question. This, I believe, will not be denied even by those who consider eczema as almost always a constitutional disease, produced by some irregularities in the functions of some organ or in the general household of the human body, and who, as a rule, look to internal or constitutional treatment as the most important part of therapeutics. It would be but natural under these circumstances to apply the same methods which we see doing good service in the hands of the surgeons. I do not doubt that this often has been done, but in most instances with disappointing results. In the early times antiseptic practice was almost identified with the employment of carbolic acid. Unfortunately this valuable remedy is not very congenial, even to the healthy skin. This is proven not only by the common experience that carbolic acid dressings after a short time are liable to produce eczema on the skin surrounding the wounds, but by the rather popular use which carbolic acid has found against all kinds of lesions and ailments. I do not hesitate to declare that I consider carbolic acid but rarely beneficial in diseases of the skin, and I feel convinced that I have certainly treated more cases which had been aggravated or directly caused by its use, particularly by the application of the popular carbolic salve, than I have seen favorably affected or cured by it. Other drugs have taken the place of carbolic acid in antiseptic surgery, but almost invariably has the effect on the skin been equally disastrous, particularly with corrosive sublimate and iodoform. It seems not improbable that this incongruity of the most popular antiseptic remedies with the skin in its healthy state as well as in pathological conditions has been one of the principal factors to prevent the introduction of antiseptic principles into the treatment of eczema.

Another cause, I believe, has been the almost universally accepted doctrine which forbids the use of water in the management of eczema. Only recently O. Lassar, of Berlin, has tried to prove that this fear of water is not so well founded and that baths are of great benefit, and Saalfeld, one of his pupils, has advocated the more extensive use of wet applications. It is a well-known fact that the antiseptic drugs act much more powerfully in solutions than in combination with oils, grease and other constituents of ointments. To obtain favorable results it would therefore be advisable to begin treatment by careful cleansing and to apply the antiseptic remedies in the form of solutions instead of the usual ointments. As this would have offended against the general rules, the method did not find favor with the dermatologists. To introduce antiseptic principles in the treatment of eczema it would become necessary to look for practical methods, independently from the usual surgical ones, which would prove advantageous and agreeable to the conditions described above and to adapt them to the wants of the skin. This I have tried to do for a number of years. Whenever an impetiginous eczema presents itself for treatment the first task will be to disinfect the diseased surface. In aggravated cases the crusts and all other encumbrances are removed with water and soap, castile soap being generally preferred, and afterwards with a solution of corrosive sublimate, not stronger than one part in 3,000 or 5,000 parts of water. Thereafter the patients are advised to wash the diseased portions with this solution morning and night by means of a pad of absorbent cotton or a piece of lint or clean cloth (never with a sponge). In the evening and if possible in the morning lint or cotton pads thoroughly soaked with the solution are to be applied for one-half to one hour, during which time the pads have to be kept constantly moist. Then the parts are carefully dried and a mild ointment, generally a ten per cent. boric acid vaseline, is rubbed into the skin and whenever feasible covered with lint or cotton and a bandage. This treatment is to be continued until a clean surface is presented on the affected parts and all suppuration has ceased, a result mostly obtained within a few days. In children, or in milder cases in grown patients, a two to three per cent. solution of boric acid takes the place of the corrosive sublimate combined with the boric acid vaseline. Infants get their daily bath as usual; on removal from the water they are washed with the solution of boric acid. Circumscribed patches of eczema, particularly those showing the most aggra-

vated conditions, are kept more or less constantly covered with cotton, lint or compresses moistened with the solution or rubbed and covered with the ointment. The results in such cases have been very satisfactory, and the moist stage of the eczema has been considerably shortened. In cases of very acute inflammation, particularly in eczema of the legs, with or without ulcers, two to four parts of acetate of lead are added to each 1,000 parts of the boric acid solution and compresses soaked with it are constantly applied for several days. This combination of boric acid and acetate of lead, which has recently been recommended by Saalfeld, has for a number of years been frequently prescribed in my service in the German Dispensary, the patients receiving about fifteen to twenty grammes of the acid and two to five grammes of acetate of lead, which they are directed to dissolve in one quart of boiled water while hot. In private practice a small quantity of glycerine and alcohol may be added; the substitution of about one-third or one-quarter of the water by lime water is of some advantage; it causes the precipitation of the insoluble portions in the shape of a very fine film.

The same applications are made in all cases apparently not infected with purulent substances, where a moist surface exists either circumscribed with the shape of the original vesicles preserved, or on larger patches. They are continued with as little interruption as possible until the discharge becomes less and the epidermis is rapidly forming a new protecting cover. Even in the dry forms of eczema, particularly in the erythematous ones, I have found the wet applications and the washing with the antiseptic solutions of great value; in chronic squamous eczema after the removal of the scales the surface is to be cleaned by means of water and soap, and then with the boric acid solution, before ointments and plasters are applied.

If so far I have spoken almost exclusively of boric acid, it is not because I consider it the only available drug for the purpose, but because it is the one remedy which is well borne under any circumstances, and on all localities, because it does not injure either the eye, ear, nose, nor the tender mucous surfaces of the sexual organs, with which it necessarily comes in contact. It is evident that under the principles of antisepsis, solutions of other drugs may be substituted and will produce equally good effects. I have used ichthyol one or two parts in 1,000 with good results, but it sometimes is irritating. Salicylic acid, resorcin, thymol, permanganate of potassium, tannin, acetate of alumina, even carbolic acid, may be quite as valuable, if prop-



erly diluted. While I have tried only a few of these remedies, I have no doubt that each remedy may prove useful and become a favorite in the hands of different men.

To a certain extent all the so-called "soothing" lotions which have been long in use and are mentioned in most of the books are representatives of the antiseptic treatment. Their soothing effect is produced partly by the water and other fluid ingredients, partly by the deposit of the sediment which they usually leave on the portions denuded of the corneous layer, the place of which they temporarily assume. But if you inquire into the qualities of this sediment you will find that their constituents are all more or less strong antiseptics. The insoluble salts of zinc and of bismuth, including dermatol, sulphur, the different salts of mercury, alcohol, tar and its derivatives, all are known to exert a strong influence on the existence or development of the infectious microbes, even the etherial oils, which apparently were added only for cosmetic purposes, have been recognized as antiseptics, so that the often despised and ridiculed infusion of camomile has been vindicated before the tribunal of science. Almost the same constituents as in the lotions we meet with in the soothing and protecting dusting powers, the tendency prevailing now to eliminate all vegetable powder, like starch, liable to decomposition, and to substitute minerals like talcum, kaoline, carbonate of magnesia and others. I can recommend from an extensive experience the addition of from 5-15 per cent. of boric acid to these dusting powders as of great value, the presence of a soluble antiseptic being desirable wherever the powders form crusts over small moist spots. It seems sufficiently evident from what has been said before that disinfection, the one principle of antisepsis, has always been playing an important part in the treatment of eczema, although not always under its own name.

Much more manifest in literature becomes the influence of the second antiseptic rule, which commands the protection of the affected parts from contamination with the infectious material, which abounds in our surroundings, in the air, in clothes, etc. Protect the skin from all external irritation! is taught quite prominently in the books, but which is the most dangerous and the most frequent irritant against which protection is needed, is not mentioned. While it is not directly or clearly stated that septic infection is the common and most powerful enemy, the ways and means recommended to obtain the desired results are all more or less founded on the antiseptic proper

of mechanical and chemical appliances. The surgeon resorts to a voluminous dressing, which fulfils its purpose in an almost ideal manner. There is no doubt that in most forms of eczema a well-selected, non-irritating dressing could be constructed, and would give excellent results; but there are different reasons which prevent such applications in practice. One of them is the frequent distribution of eczema over the entire body, or at least over several extremities, and the frequent occurrence on the face and scalp, which largely increase the difficulties and inconvenience of fixed dressings. Besides, patients suffering from skin diseases are much less able or willing than those suffering from injuries or from surgical disease requiring operations, to submit to so much sacrifice of time in order to free themselves of an affection which they are inclined to consider of minor importance. Sometimes the desire to keep their skin troubles a secret from their surroundings, owing to the distrust with which they are looked upon by many people, would interfere with a treatment which would prevent concealment. Hence, the efforts in dermatology to find other means to render applications as permanent and as compendious as possible. It is not necessary to review all the numberless products which have been offered to the profession within recent years; the salve mulls, the gelatines, traumaticin, bassorin and plasment, and the many varieties of plasters. I have no doubt that everyone of these preparations is of some value, sometimes for special conditions, sometimes for special localities. Common to all is the presence of some drug which while of sufficiently strong antiseptic qualities, favors the formation of a new firm epidermis; salicylic acid, resorcin, ichthyol and the old reliable tar probably being the most appropriate ones. Almost all the modern remedies owe their claims to their antiseptic action, their usefulness will increase in proportion with their deleterious effects on pathogenic microbes on the one side, and their non-irritating character towards the skin on the other. Some plasters furnish an almost ideal antiseptic dressing, their only shortcoming being the want of absorbent qualities. Supplemented by a few layers of some septic gauze or cotton they come very near the dressings of the surgeons. If you compare the different methods of treatment advocated by different dermatologists, it will not be difficult to discover in every one distinct traces of antiseptic principles. If, then, the common principle on which we all act, intentionally or unintentionally, is openly acknowledged and proclaimed, the apparent discrepancy of opinions among der-

matologists, which undoubtedly stands as a severe reproach for them in the eyes of the general profession as well as of the patients, will dwindle into insignificance, and every plan of treatment founded on such principles, will easily command the respect and the approval of every dermatologist.

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OPINIONS OF A NOTED JAPANESE SPECIALIST IN MATTERS  
OF LEPROSY.

BY

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New York.

THERE is a book published in Tokio, 1882, by the Goto family, and written by Goto Sho-choku, the son, and revised by the father, Goto Shobun. The title of the book is *Nambio-ji-riyo*, and means, home treatment of leprosy. These two are the most eminent leprologists in Japan; they have in charge the largest Japanese leper hospital. The father was a friend of the late king of the Sandwich Islands, whose investigations on leprosy, on the king's visit to Japan, he directed. The two doctors have separately visited the lepers in Molokai on behalf of the Hawaiian Government. They may therefore be considered as good authority as can be wished for on the subject of leprosy. I have therefore thought it worth my while to go through the whole work of these eminent Japanese, aided by my friend, Mr. Tsuchiya.

Mr. Sasaki, or rather the Viscount Sasaki, introduces the book in the customary Japanese style, by a motto: "With merciful winds," says he, "nourish mercy." He means, probably, to recommend the poor victims of leprosy to the pity of their fellow men.

The preface is by Mr. Nagasaka, a friend of Dr. Goto. "Leprosy," says he, "is a very ancient disease, and was ancient even in Confucius times. It is related that a pupil of Confucius (Hakugin), being sick, received the visit of his master, who, taking a position outside of the window, took hold of the latter's hand through the casement, and said to the other pupils who stood about him: 'Here is a good man who has this hateful disease.'<sup>1</sup> What disease? It must have been leprosy, says Mr. Nagasaka, for otherwise Confucius would have entered the house, which he did not." This argumentation,

<sup>1</sup> "Kono hito, nishite, kono yamai ari."

perhaps, would not satisfy an Indo-Germanic mind ; but it seems to be perfectly convincing to the Japanese author. "Although this disease is so old," says he, "there is yet no medicine to cure it." We further learn that "Goto Shobun has of late invented a cure, and erected a hospital in Tokio, where many hundreds of lepers have gathered around him." The son of this inventor is the author of the book *Nambio-ji-riyo*, which is, to Mr. Nagasaka's knowledge, the only one that ever promised a cure of leprosy. The author of the preface has so much faith in the new method that he thinks that "had Confucius known of it, he would have said to him not 'this man has this disease,' but 'this disease has this man.'" <sup>1</sup> This is a Japanese idiom which might be translated by, "this disease has found its master in this man."

The book tells of the existence of leprosy at the time of the Empress Kōmyō. She was the wife of the Emperor Shomu, who reigned from 718 to 740 A.D. He built the great "Daibutz," bronze Buddha, in Nara, which is one of the oldest monuments of Japan.

The following legend, which I introduce here in my own name, shows that the belief in the existence of the disease, at that comparatively remote period, is quite a national one. The Empress had sworn to wash the bodies of a thousand lepers, a self-imposed task of castigation. She in consequence built a number of baths and asylums, in her castle at Kiota, and every sufferer from leprosy who presented himself at the gate was admitted to be washed by her royal hands. When she had cleansed nine hundred and ninety-nine she found that the last was the most offensive of all ; but she did not shrink from the uncongenial task ; she washed him gladly, and thus satisfied her vow. But lo ! when she had done, the body which she had purified, was enveloped in light, and it was not a man, to whom she had rendered her service of mercy, but Buddha himself. Considering that this legend mentions a thousand lepers, it is reasonable to assume that the disease had existed long before.

According to Goto, the disease is not contagious ; this is at least his conclusion from his studies in Japan. But the Hawaiian experiences puzzle him ; the disease came thither from China, spread rapidly, and soon grew severe.

According to the Japanese profession in general, leprosy is inherited. Goto thinks otherwise, or says he does. But the fact

<sup>1</sup> "Kono yamai nishite, kono hito ari."



that such an assurance, or profession of opinion, is the surest means of pleasing the Japanese of all classes, detracts much from the author's reliability. In the present state of public opinion, the appearance of leprosy in one member of a family ostracizes the whole clan.<sup>1</sup>

Statistics in Japan, according to our author, show apparent heredity in only twenty to thirty per cent. "Excepting these," he says, "the disease is always *spontaneous*" (sic).

The following causes propagate the infection: parasitical skin diseases, small pox, pregnancy, syphilis, measles, ring-worm, vitiligo, bruises and wounds, uncleanness of body, carelessness of sanitation, excess of sexual intercourse, living in swamps. Sometimes it follows drunkenness, eating of whale flesh and maguro or tunny fish, horse and cat flesh, snakes, or other unusual articles of food. These act as poison; in fact, leprosy is always the result of some kind of poisoning. This extraneous poison acts as an irritant on the hidden principle of leprosy in the system.

Leprosy occurs mostly among males from the age of twenty to that of thirty. In supposed hereditary cases it appears among males, between the fourteenth and the fifteenth years, in females between the thirteenth and the fourteenth years. Here, apparently, the growing passions of the subject are the irritating cause.

The author here overlooks the great skin changes taking place at the period of puberty, and which are more likely to favor the eruption of the disease than mere psychical causes.

Leprosy sometimes occurs in old people, never in younger children and babies.

It is often mistaken for mere skin disease, but as it is not curable by acupuncture and moxæ and other local means, it can hardly be considered as concerning exclusively the skin. Goto Shobun, the father, believes it to be a distemper of the blood in which its poison abides.

The blood is to the body what the atmosphere is to the earth. When the blood is poisoned by the principle of leprosy

<sup>1</sup> Let me observe here, that any one who knows how many leper villages are spread over Japan would naturally believe that this state of things was the consequence of a belief in heredity. But it is not so. When a member of a family finds himself stricken by leprosy he is very often accompanied in his retirement by all the members of his family; they will not allow him to sacrifice himself in order to save them from the leper ostracism. It is, in my opinion, this admixture of an enormous amount of pure blood with the contaminated one, in leper villages, which has counteracted the law of immunity after four generations of lepers, marrying with lepers.

it loses its nourishing power and, moreover, fails to carry out the waste particles. Insufficiency of good blood is the cause of all the symptoms of leprosy : paralysis of nerves, skin eruptions, whether white, black or purple, etc. The lack of nourishment of the tissues explains all the symptoms. The nerves losing their original power, the sensibility is dulled and the skin is easily damaged by cold and heat, etc., of whose inroads he is not informed by his blunted sensibility. In one word, leprosy is deficiency of blood nourishment. This is shown by the fact that whenever the blood of a leper is improved, or brought back in some manner to its former condition great benefits are always observed. This is the foundation of the elder Goto's cure of leprosy. The method consists in improvement and purification of the blood, application of medicines to invigorate and increase its constituents, and other medicines to eliminate from the body the poison of leprosy, if any such poison exists.

The author is particularly struck by the fact of the falling out of hairs, eyebrows, mustaches, whiskers, etc. This, he thinks, must evidently be attributed to deficiency of nourishment ; a peculiar constituent necessary for the alimentation of the hair has disappeared from the blood, and this special vital element must be restored. The author overlooks the influence of the climate. We know that northern people who settle in Florida are apt after a few years to shed their hair under no other influence but that of the climate.

Stages of leprosy : In earliest stage, flushings in the face, formications and itchings on the skin, electric shootings through the body, constipation, scanty or no menstruation in women, uneasy feeling, low spirits, declining strength, stomach disorders, chilliness and sometimes a feeling of heat. Or the disease may break out suddenly through one of the above-mentioned causes, as drunkenness, eating of whale, etc. In this case there is a feeling of cold and hot, spots on the skin, painful swelling of the face, dizziness, delirium. These symptoms disappear temporarily, and there are all the appearances of a cure ; but gradually the sensibility is lost, the skin changes color, the mouth and ears undergo various deformations, etc.

We have thus two classes of symptoms, each belonging to the first stage of leprosy, the one advancing slowly, the other emerging with suddenness.

In the second stage, the toes, thighs and elbows lose their

feeling; the eyebrows fall out, eruptions of the skin appear. These symptoms occur after the poison has been in the blood two or three years, the patient not being conscious of his condition. It is in this stage that he first becomes aware that he is a leper.

Third stage: Continued appearance of eruptions, swellings, which look like results of burnings, on face, feet and hands; changes in color of skin. These symptoms constitute *wet* leprosy. There is another set of symptoms of the third stage, which the author calls *dry* leprosy. No change of color of the skin; only atrophy and emaciation, no eruption, no swelling. There is a considerable loss of sensibility. The skin is glossy in appearance. This dry form does not give the patient the same repulsive appearance as the wet form. The latter is peculiar to fat or plethoric people: it rarely affects thin persons. The special appearances of wet leprosy are spotted eruptions and putridity; the color of the spots may be dark scarlet, brownish or purplish black, or white, usually maculated, indurated, shiny in appearance. The shape of the spots vary; some are round, some angular, some ring-shaped. They are most frequent on hands, feet and face. They are at first very small and grow larger gradually; some run together. In bad cases spots cover the whole skin. Their character is of two kinds: quick spreading or slow spreading. The first kind is accompanied with heat and swelling; its color is usually dark scarlet; there is a white desquamation. Sometimes small eruptions run together like ringworms; these are isolated; they do not represent the true leprous spot.

Eruptions are rare on the covered parts of the body, chest and abdomen, which suggests the obvious idea that the climate plays its own part in the development of the disease; there is a weakening of the protective power of the nerves of the skin, caused by excess or deficiency of heat, in swampy places or on the seashore. The eruptions increase in number, and the skin is roughened like a pumpkin. They develop even in the nostrils and in the mouth, and may gradually invade the throat. Their surface is anæsthetic. One kind does not change; another kind turns putrid. The skin and flesh putrefy, and there is a continuous flow of offensive pus. This follows sometimes on simple scratching of a ringworm or other eruption, and leprosy develops at once. The putrefaction of leprosy is never promptly cured; it grows worse and worse, eating finally in the bone.

The worst condition of all is that when pieces of bones fall out from the bottom of the putrid sore; this usually happens in the sole of the feet.

As in leprosy, most parts of the skin have become anæsthetic; they are readily broken through accident, the skin having no warning by nerves.

The peculiar appearances in dry leprosy are eruptions, absence of feeling, atrophy of muscles and emaciation. These conditions develop gradually; most of the victims are at first unconscious of their existence. Some cases are altogether unaccompanied with eruptions. Subjects affected with dry leprosy have the appearance of anæmia, but it is only an appearance. The eruptions are very small, some pustular, some vesicular, some confluent, as in wet leprosy, others in the shape of rings on belts. Their color is scarlet, grayish-red, brown or yellow. Some form scabs, some are dry and some are wet; they may be accompanied with pains and itching, though most cases are painless. The eruptions of leprosy are to be cured only by curing the leprosy proper, not by any external application. *Anæsthesia* is usual in spots and eruptions, but appears sometimes on free places. At first there is a feeling as of paper on the skin. It increases gradually, so that finally not even the pain of burning is felt. The part presently becomes very cold and dry. Persons in this condition should not be allowed to be near a fire or a kettle of boiling water.

*Loss of flesh and atrophy* are two further symptoms. The anæsthetic muscles cease to be used sufficiently, and therefore being less nourished, atrophy. The two sets of symptoms, those of the dry and those of the wet leprosy, commingle sometimes; spotted eruptions and putrifaction appear in dry leprosy, and wet leprosy occurs without spots or eruptions. Sometimes there is no atrophy in dry leprosy. Some cases of leprosy cannot be classified as belonging to either of these forms. However, the two classes are, as a rule, clearly distinguishable from one another. The classification into dry and wet leprosy is of the greatest convenience for the treatment. The following conditions may be said to be common to both forms: falling of hairs, early in wet, late in dry leprosy. The loss of hairs is greatest on the head, then come the eyebrows and lashes, then the body. Rarest is the spoliation of the beard, mustache, armpit and pudenda. The first hairs to fall are those of brows and lashes, which at once gives a peculiar expression to the facies. The hair of the beard, mustache and



head, comes in a later stage. The hairs of the body fall as the eruption reaches them.

*Crooked fingers* are seen mostly in the early stage of dry leprosy: it usually follows atrophy and putrefication. The first finger that becomes crooked is the little finger. The crooking of the finger is peculiar; the proximal phalanx always bends backward toward the extensor side, the middle and distal phalanges bend toward the flexor side; the deformation is accompanied with atrophy and insensibility. This is the so-called leper claw. All sensibility and motion is finally lost.

*Dropping off of fingers* occurs in both leprosies, dry and wet. In some cases putrefaction, eating to the bone, precedes it. Sometimes the fingers fall off at joints, at others without putrefaction, the fingers seem to contract, and the bone disappears by melting, so that the nails are left on the stumps. The hand appears like a club.

*Nervous pains.*—The nerve is being eaten up by the poison, hence the pain. In healthy bodies the nervous pains are felt on every part of the body; but in leprosy are only felt on the flexor side of the arm and forearm. Touched by the finger, the latter give the impression of stretched cords. It is this stretched condition of the nerves which causes the suffering. An eruption on the nerve resembles the grains of a Buddhist rosary. The nervous pains are more frequent in dry leprosy. When the pains are very severe, they interfere with the taking food; hence weakness and sometimes utter starvation. These sufferings may be partially relieved, but nothing can prevent the atrophy and the crooking.

*Eye diseases.*—Most lepers have some form of eye disease. The skin of the lid hangs down; it gets loose, standing away from the eyeball. Whenever the control of the eyelid is lost the eye is not protected, and inflammations and ulcerations may be expected; also opacities of the cornea follow. These conditions of the eyes cannot be cured by the ordinary local treatments.

*The falling in of the nose* is very common. There are two kinds of it; it may fall by putrefaction in the nostrils or more gradually, without putrefaction. This latter results from deficiency of nourishment.

*The termination of leprosy.*—The end, in wet leprosy, comes very soon; it is much slower in dry leprosy. A man with wet leprosy dies from 7-8 to 10-15 years, while in dry leprosy he lives with this disease from 15 to 20 years. The conditions

which determine the end are either *dropsy*, or *diarrhœa*, or *debility*. The *dropsy* is very hard to relieve. It appears first in the legs and testicles; locomotion is interfered with; urine is suppressed; great thirst. In one or two weeks the dropsy spreads to the trunk, upper extremities, and face. The pulse becomes rapid, the breathing short, and death ensues. This form of death has a striking resemblance to that of kakké.

*Death by diarrhœa*.—It is not so quick as it is in contagious dysentery. The purging is not so frequent; at first two or three times a day; afterwards 5-6 to 10-15 times. After a couple of weeks the body loses strength, mental powers fail, the patient falls into melancholy; he expresses great anxiety about his appetite, which is declining; he tries in vain to find some food that he can enjoy; but whatever he eats only increases the purging. The stools are painless; they are watery and of offensive odor. When these conditions have continued for some weeks the patient is exhausted and dies. His hands and legs, in his last moments, are exceedingly cold.

*Death by debility*.—The debility is not always the effect of the disease; it is often due to injudicious treatment. There is a worthless old method called the *reducing* treatment, in which fat, flesh, fish, and rice are all prohibited. Of course such a treatment is essentially wrong, if, as the author teaches, leprosy is the result of deficiency of blood. The disease itself has a tendency to diminish the strength of its victims. The process of emaciation continues until death.

*Complications of leprosy*.—Inflammations of brain and of the throat, fevers, syphilis, the two latter are the most dangerous. Fever causes death rapidly; syphilis also makes a quick end of the patient. Lepers should always be careful not to contract syphilis. Stomach diseases are also complications, chronic catarrh especially, which depresses the strength.

*Treatment*.—It is based on two principles: first, to improve the blood; second, to cure the accompanying morbid conditions.

The hygienic means and the secret remedies used are those employed by the author's father. Four kinds of medicine are used; the first is the invention of the author's hospital, and is called the king of medicines; the other three are called subjects, or ministering medicines. The first is given inwardly, the second is given in a bath. Same treatment for both dry and wet leprosy. Half a year's treatment, the author is confident, will effect a cure, though a year's treatment is earnestly recommended. Let us observe here that Goto claims for his nostrum

a supernatural power, and he congratulates the present generation of lepers for living in his own times. Let them not let this precious opportunity slip by!

The wet form is easier to cure than the dry. Oil plasters are applied to the spots, and if tumefaction and a stretched feeling and heat come on, all treatment must be stopped. If a great deal of inflammation arises, apply cold cloths.

Dry leprosy is slower of progress and also of cure. Iron-water is recommended to strengthen the body, electricity for paralysis, massage for the muscular atrophy. The falling of the hairs is, of course, incurable, as the hair-bulbs are destroyed. Chronic crooking of the fingers is likewise difficult to remedy. Forcible extension is thought useful. Most persons who have died in his hospital ended with dropsy. He, therefore, considers dropsy as the most dangerous symptom. Purg-ing, also, is very dangerous, because it resists both opium and tannin.

In the second volume Goto gives some advice as to the use of the remedies which he offers to those who will have confidence in him. They consist of pills, medicated baths, powders, one of which is to be boiled in water. Other remedies are purges, plasters and pills, which he calls assistant remedies. Of these latter there is a second series, consisting in iron-water, iron pills, stomach remedies, and diuretics. Of course, as we have already said, what the remedy really is he does not reveal, enumerating in these lines only its different forms and applications.

*Hygienic methods:* First, *sanitary condition of dwelling place.* Let Japanese imitate in this the Western people, that they improve their houses as much as possible. Diseases, closely allied with the conditions of living places, are those of the lungs, of the womb, and beri-beri and leprosy. Leprosy is mainly a disease of hot countries, rare in cold climates; it is, therefore, reasonable to assume that the heat is favorable to this disease, and that cold is contrary to it. Hence it seems clear that cold should be employed in the cure. Although heat is etiologically connected with leprosy, yet it does not make the cases of leprosy worse, when they once exist, while cold, which is unfavorable to the formation of the disease, has a very bad effect on the condition of the lepers.

This is how he explains this strange effect of heat and cold. The action of the leprosy poison and the action of the blood are antagonistic. The poison of leprosy is continually active in

destroying all the tissues which it can reach. Its power is greater than that of the blood, and the blood is, as it were, continually defeated by it, so that reconstruction can never find a favorable interval. If now the cold touches the skin, the blood is driven from the surface to the interior, and, the poison on the surface of the skin finding the resistance diminished, redoubles its activity. This is how coldness favors the operation of the morbid principle of leprosy.

Whatever may be thought of this flight of theory, there are some facts which lend it plausibility, the places where the symptoms of the disease appear are those which are most exposed to influences of temperature, face, hands, feet, etc.

Warmth, moderate heat, is favorable to the course of the disease, but excessive heat has a contrary influence. In a very hot climate, says he, the nerves are exhausted and the skin becomes inelastic, which gives the disease full play. On the other hand, diseases of the stomach and intestines, and contagious diseases, which lend to the leprosy poison additional intensity, are also more rampant in hot climates. Lepers should, consequently live in a temperate climate, and avoid excesses both of heat and of cold.

Besides the conditions of temperature and the dwelling place, it is necessary to consider the ground and the atmosphere. Wet air and wet ground, that is, humidity, swamps, river-sides, valleys, sea-shores, are unfavorable to the leper. The best place for him to live in is one situated far from sea and water courses, in dry air, on elevated grounds.

*Air* : The purity of the air is of great importance; as the poison is working in the blood, pure air is indispensable to counteract it. There are many who, while they are very careful about what they eat and drink, do not think of the equal importance of good air. Many causes contribute in vitiating the air: breathing, burning of fuel, etc. Let, therefore, lepers eschew closed rooms, and live only in ventilated spaces. Dust also is pernicious: industrial towns are therefore no fit residence for lepers.

Certain parts of the atmosphere are infected with special poison. There is the swamp poison, the effluvia from sick bodies, malarial emanations.

*Food* : The appetite should never be completely satisfied, because the stomach of lepers, as a rule, is very weak. Eat only when hungry, and then nutritious food.

*Clothing* : The clothing must serve the purpose of protect-



ing against cold ; such stuffs as are favorable to the evaporation of sweat are to be preferred. Flannel and merino, rather than soft cotton, silk and linen. Loose garments are best.

*Sexual intercourse*<sup>1</sup> : This is more pernicious to lepers than to sufferers from any other disease, for it weakens the blood, and reduces the vitality. It is therefore uncompromisingly prohibited by the author. Besides, no healthy child can be born to a leper. If he has a wife, it is his duty to leave her. Masturbation, of course, is worse than anything, and entails a great deal of trouble on our author in his hospital, where he has had to watch his patients to the very last breath, to protect them against self-contamination.

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CASE OF MOLLUSCUM FIBROSUM.

BY

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WILLIAM RICKETTS, aged fifty-eight, married, no children, occupation, laborer.

He was born near Sing Sing, New York, from whence the family removed when he was a child to the State of Indiana.

When he was a boy he was in the habit of going swimming in the canal near Fort Wayne, Indiana.

The water in the canal was generally very muddy, never very clear. One day, when about ten years of age, he had been swimming in the canal for several hours, and the weather was cold and chilly.

Upon going home he felt very weak; he had nearly fallen from pure weakness while climbing over a fence on the way home. On reaching home he went to bed, feeling very sick, so sick, indeed, that he did not remember any of the particulars. The next day a physician was sent for, who pronounced his illness to be erysipelas.

Both his face and trunk, chest and abdomen were wine-red and very much swollen, and he had a high fever. His eyes were entirely closed. He was sick for over a month.

During his convalescence his skin peeled off entirely from his face and body.

<sup>1</sup> That our author thought this paragraph necessary shows that the sexual instinct is by no means dead in the leper, as many people suppose.

Soon after this small elevations or tumors appeared on his breast, rapidly spreading over his whole body. No other mem-



FIG. 1.

ber of his family has been similarly affected. He does not know of any scrofula, cancer or tumor, or anything of the sort in any of his relatives. His father and mother have been

dead several years, he does not know exactly how long, nor of what they died.



FIG. 2.

*Status praesens.* He is an undersized, loutish-looking, stupid person, evidently of defective intelligence.

His body and limbs, especially the trunk, are thickly covered

with very uniform, pea-sized tumors, presenting the physical characteristics and microscopical appearance of *moluscum fibrosum*. These excrescences are sparingly scattered over the head, neck and limbs; but on the chest, back and lateral regions of the trunk they are as thickly studded as it is possible for them to be, to the number of thousands. There is mention made of a certain case in which 3,000 tumors were counted, and I feel satisfied that this patient has even more than this; but he would not allow them to be counted.

The only noteworthy features of this case are, in the first place, the apparent connection between the growths and the attack of erysipelas, and secondly the extreme uniformity of the tumors as to size. In all the other cases that I have seen figured there have been one or more tumors that have surpassed the others in size, some of them being very large indeed and assuming a pendulous or polypoid appearance.

The photographs (see Figs. 1 and 2) give a better idea of the patient's appearance than any description could possibly do, and as all the literature of this subject consists in the report of cases, and as the affection is by no means a common one, I have thought it worth while to add this case to those already reported.

The patient makes no complaint of the tumors, except that those on his head prevent his combing his hair, and one situated just at the extremity of the coccyx became irritated in some way and suppurated, and it was his applying for relief to this which brought him under my observation.

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## Correspondence.

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### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

**The Actual State of the Question of Prurigo and Lichen.**—We ask permission to-day of our readers to leave a little to one side the therapeutic novelties which ordinarily form the subject of our correspondence, and to treat of a question which at first sight is purely theoretical, but which is in reality of the greatest importance and one of the most controverted of dermatology, which has often of late years occasioned the most passionate discussions. We would speak of prurigo and lichen.

Although the greater number of physicians look upon these scientific speculations as useless, we believe them necessary so far as we are concerned, for they permit a better comprehension of the true nature of the dermatoses, to render them precise, to diagnosticate them more surely and, consequently, to treat them better.



It is well known that since the works of E. Wilson and of Hebra most authors reserve the name of lichen for a dermatosis which is well defined both in its objective aspect and in its evolution, lichen ruber and its different varieties. All the other dermatoses denominated lichen by the older writers have been ranged among the chronic eczemas, the lichenoid eczemas, or along with prurigo, keratosis pilaris, etc.

It is our regretted and venerated master, E. Vidal, who first had the honor in France of instituting a reaction against this rather too radical simplification. He endeavored, as early as 1886, to show that the lichens of the older authors enclosed other special cutaneous affections whose individuality should be preserved. It is thus that he described an acute lichen simplex—to which we will revert later on—a chronic lichen simplex, a polymorphous lichen mitis which corresponds more particularly to professional eruptions in predisposed subjects, a polymorphous lichen ferox which is in reality prurigo.

**Chronic Lichen Simplex, or, Better, Chronic Circumscribed Neurodermitis.**—This first protestation passed almost wholly unnoticed until we, aided by our excellent friend, Dr. Jacquet, in the solution of the question of pathological anatomy, demonstrated in 1891, in the most irrefutable manner, by numerous clinical examples and by the methodical discussion of the facts that there exists a special dermatosis, the one to which E. Vidal had given the name of chronic lichen simplex, and which is objectively characterized by circumscribed plaques, quite limited, unique or multiple, at times symmetrical, over which the skin is thickened, indurated, of a pale rose or of a somewhat somber red, often pigmented, the folds of the derma exaggerated in such a way as to form a most pronounced criss-cross appearance, the epidermis roughened, covered with adherent furfuracious desquamation, the whole excoriated by scratching. The pruritus is paroxysmal and not continuous, but of the most violent nature. At times, surrounding the central plaque (zone of infiltration) there exists a primary peripheral zone, which is pigmented, of a yellowish brown hue, of a velvety aspect caused by hypertrophy of the papillæ of the derma, with a beginning of the checkered appearance; and then a second middle zone which is papillary, over which are seen small pseudo-papillary elements of irregular form and contour, usually rounded and roughened by very small elevations corresponding to the summits of the papillæ of the hypertrophied derma, at times acuminate, at times flattened, with shining apex like those of the lesions of lichen ruber planus, which they resemble to the extent of leading one into error. The confluence of these elements forms the central plaque. The regions of predilection of these particular lesions are the neck, the groins, the internal and superior portions of the thighs, the region between the thighs, the wrists, the antero-inferior portions of the forearms, the axillæ, the popliteal spaces, the palms of the hands and the soles of the feet, the lumbar region and the scalp.

In studying the genesis of these lesions we were enabled to convince ourselves—Dr. Jacquet and I—that they form in consequence of incessant scratching. Pruritus is the first symptom which appears; the patient scratches; the skin becomes little by little modified under the influence of the incessant traumatisms to which they are subjected, and gradually we see developing alterations of the derma, which we have just described. His-

tological examinations show, furthermore, that they are only constituted by the pathological modifications characterizing the banal inflammation of the skin. This affection is essentially rebellious, chronic, and subject to incessant recurrences. It develops, especially in neuropaths of sedentary profession, under the influence of violent perturbations, of griefs, emotions, etc. They may coincide with very definite neuroses, with chorea, hysteria, vitiligo, etc. They may alternate with certain visceral manifestations called arthritic, such as neuralgias, bronchitis, attacks of asthma, etc. It is for the purpose of indicating its narrow relations with the *neurosis* of its subjects, its constant development after scratching, due to a preceding localized pruritus, that we have given to it, with Dr. Jacquet, the name of *névrodermite circonscrite chronique*. These ideas have quite recently been developed, and sustained by numerous documents in support, by one of our students, M. Tabart, who made of it his inaugural thesis (November, 1893).

**Theory of Lichenification.**—We have just seen that chronic lichen simplex, or circumscribed chronic neurodermitis, is in reality the result of traumatism exerted by the patient upon the pruriginous point. This fact demonstrates in a pre-emptory manner that when we cause, in morbid condition of the skin, numerous and repeated traumatisms, we can determine with greater or less rapidity cutaneous alterations which consist essentially in a chronic inflammation of the integument. The derma is, little by little, infiltrated with embryonal elements; it becomes thickened, hard and roughened; the papillæ become hypertrophied, even at times grouped in a way to simulate papules of irregular and unequal size. After a more or less long interval of time the skin presents quite a special aspect, characterized by the exaggeration of the natural folds forming quadrilateral forms with meshes more or less large and regular, and by an infiltration of the integument more or less accentuated, it having lost its pliability and normal consistence. Such is the process to which I have given the name lichenification; all degrees may be observed in the modifications which the tissues undergo. At times they are quite thick, deeply furrowed, roughened, with pseudo-papular elements of large size. The lichenification is in these cases very marked. They may be only moderate; they may also be but slightly marked. At times the integuments have, so to speak, undergone noticeable thickening; and, nevertheless, when closely observed, one sees that their folds are exaggerated; that in the interval between the folds it is possible to see what look like little facets, flattened and shiny, recalling forcibly the small elements observed in the onset of lichen planus. In this case the skin has often lost its normal color and has a swarthy hue. The lichenification is then worthy of the name of aborted lichenification. All those who have pruritus and who scratch do not cause lichenification of the affected regions with equal rapidity. It seems, on the one hand, that there are affections which modify the vitality or the nutrition of the integuments to such a degree that lichenification is produced with the greatest facility in those affected, while in other pruriginous diseases the resistance of the skin to an equal amount of traumatism seems to be normal, or even increased. On the other hand, there are subjects who would seem to be predisposed more than others to see their skin undergo the modifications which we have just described. Hence, by the mere fact that a patient is affected with pruritus

in a particular point of his body, and that scratching ensues during a certain time, we must not think that the regions implicated are surely going to undergo lichenification. It is necessary, in order that lichenification is produced, that the disease predisposes to it, and very probably that the patient is predisposed to it himself. Now, lichenification may be produced from the first in a skin which is sound, at least objectively, or in a skin already attacked with a previous dermatosis. The first group of cases constitutes what we have called *primitive* lichenifications, in which the lichenoid state is pure and constitutes the sole eruption. These primitive lichenifications are divided into two principal categories, according as they are circumscribed; and in this case it is our *névrodermite chronique circonscrite*, the chronic lichen simplex of E. Vidal, and according as they are diffuse, and in this case they constitute the affections to which we have given the name *névrodermites diffuses*. These primitive lichenifications are the only affections which are truly worthy of the name lichen in the older sense of the word. The second group of cases is enormous. It does not comprise the true lichens in the older sense of the word, but the lichenified dermatoses, since all pruriginous affections of the skin of which the manifestations are quite fixed give rise to important traumatisms, which determine, after a certain time, a certain degree of lichenification of the integument. We observe these secondary lichenifications in the chronic eczemas, in the artificial and professional eruptions (*lichen polymorphe mitis*, E. Vidal,) in the pruriginous psoriasis, in the lichen ruber planus, the mycosis fungoides, the pityriasis rubra, but, above all, in prurigo, of which it constitutes one of the most important symptoms. Lichenification is, hence, only a syndrome testifying to intense pruritus and repeated scratching, denoting a sort of trophic cutaneous trouble, but not constituting, properly speaking, by itself a well-defined dermatosis; it can, in effect, complicate morbid states very diverse. This general notion is indispensable to arrive at a comprehension and classification of the affections in which it is observed.

**Diffuse Neurodermitis.**—The patients who are attacked with these affections are neuropaths. Under some influence which calls into play the excitability of their nervous system in a more acute way they are affected with more or less extensive itching, even at times urticaria. They scratch, and little by little the skin is seen to become modified, take on a more swarthy, or brownish color, the folds become more pronounced in such a way as to form a fine basket-work, between the meshes of which are seen diminutive papulous, shining elevations resembling a little the papules of lichen planus in its beginning. The sites of predilection of these lesions are the external surface of the limbs, the internal and superior portion of the thighs, the whole trunk, especially the lumbar region and the lower abdomen. They are almost always symmetrical. From an objective point of view these are abortive diffuse lichenifications.

**Prurigo Simplex** (*Lichen simplex, acute*, E. Vidal).—We have already stated that polymorphous lichen mitis of E. Vidal corresponds essentially to the lichenified professional eruptions, that his polymorphous lichen ferox is nothing else than the prurigo of Hebra, and we do not wish to dwell further upon this point. However, our venerated master claimed the right to insert in the list of dermatological diseases acute lichen simplex, which, until recent times, has been left in obscurity. We have recently made a



study of this particular point, and here is a resumé of the memoir which we presented in January, 1894, to the Dermatological Society of Paris.

Vidal's acute lichen simplex exists, but it has nothing in common with his chronic lichen simplex; it never, indeed, presents either eczematization or lichenification; there results from it only chronic forms which, corresponding to the acute lichen simplex of Dr. Vidal, are not at all his chronic lichen simplex. We can not, then, conserve the nomenclature of our master, which leads into confusion. Now, it is with Hebra's prurigo that acute lichen simplex presents the greatest affinity, and we have hence proposed to name it prurigo simplex acutus; the epithet simplex indicating that it is only constituted from an eruptive point of view by papules, which we will describe, and that it is never complicated, as is Hebra's prurigo, on the contrary, with eczematization and with lichenification. The prurigo simplex acutus begins in quite a sudden manner, almost always there is perfect or nearly perfect integrity of the general condition. Quite frequently the eruption seems to commence by elements of urticaria, or at least by papules of characteristic appearance seeming to form on an urticarial base; the greater part of the patients being susceptible to urticaria. The eruption begins ordinarily upon the upper extremities, at times it invades the neck at the very start, occasionally it seems to be produced simultaneously upon the divers points of election, which are the external surfaces of the extremities, the knees and the elbows, the dorsal surface of the hands and fingers, the neck, the buttocks, the anterior and posterior surfaces of the trunk, the dorsal surfaces of the feet and the face. The characteristic elementary lesion is a little papule which is at first rosy, then of a more or less lively red, perhaps coming on after pruritus and scratching, exceedingly congestive, its dimensions varying from a medium-sized to a large-sized pin's head, and even as large as a lentil; it is rarely hemorrhagic. When quite recent it has at its summit a faint bluish tint or is opaline, from a small accumulation of serum forming a diminutive vesicle. Very rarely it becomes frankly vesicular. According as evolution progresses it becomes covered in the center by a sort of adherent crust having the dimensions of a small or medium-sized pin's head, the color of which varies from a brownish yellow to a dark brown. Surrounding this little crust a fine lamellar desquamation is often produced. This little crust is the natural product of the evolution of the papulo-vesicle and of the dessication of its center; however, we find, disseminated here and there, excoriated elements covered with little blackish red crusts, characteristic of excoriated pruriginous lesions. After these little crusts have fallen and the papules have been resolved there usually remains a light pigmentation of brownish color, which little by little disappears. At times they may be absent and they may at times be replaced, especially in subjects who have scratched themselves, by little white cicatrices, rounded and having a mother-of-pearl aspect. Each lesion takes at least from six to eight days for its evolution.

The papules are always distinct from one another, are never agglomerated so as to form true plaques of infiltration. There is never produced in this disease eczematization nor true lichenification. The affection is eminently pruriginous. The painful sensations almost always present periods of relative calm and repose followed by exacerbations coming on especially toward evening or during the night. The whole duration of the disease varies from two weeks to two months on an average. Recurrences are quite



frequent. They occur in some cases in quite a regular manner, especially during the Summer. This morbid type is quite special. It cannot be included under urticaria, which often complicates it but from which it differs by the characteristic papule and by its evolution, nor can we class it with the erythemas since it differs from papular erythema by its appearance, localization and subjective phenomena, neither can we place it with the miliarias for its lesions are too large and too papular, nor with true papular eczema, for one never observes with it plaques of veritable eczemization, nor with the lichen ruber acuminatus neuroticus of Unna, for its papules do not form around the hair follicles, have no tendency to give rise by confluence to large plaques, for it is never accompanied by a grave general condition nor with Hebra's prurigo, since it is a dermatosis of acute tendency and curable, being capable of developing at any age and never complicated by eczemization or lichenification nor with the diathetic prurigos having the eczemato-lichenoid form of our excellent master, Dr. E. Besnier, for similar reasons. This *prurigo simplex acutus* is frequently observed in infants, where it has been given the name of strophulus. It coincides in these patients, so to speak, with urticaria, and it is usually described as an infantile urticaria. In analyzing the clinical facts we find a whole series of intervening cases stretching out between this acute prurigo simplex and types whose chronic rebellious recurrent features recall altogether the physiognomy of the true prurigo of Hebra, while always differing in the fact that they occur at any age, that their eruption is constituted by the eruptive elements which we have just described and by the absence of eczemization and true lichenification. We can distinguish among these cases of passage those tending to prolong their course through several months and worthy of the name *prurigo simplex subacutus*, those whose tendency is truly chronic and rebellious, worthy of the name *prurigo simplex chronicus recidivus*. Among the last there are some which in their ensemble present the general physiognomy of typical cases; there are others differing in their localization, somewhat isolated (neck, upper portion of thorax, pelvic region), localizations which remain the same during the whole course of the affection; there are finally those which, instead of appearing especially in the heated seasons, occur especially in the Winter; these are the cases worthy of the name atypical forms of prurigo simplex chronicus. This whole series of cases is observed equally in the adult and in the infant; in the latter, as we have already said, constituting the varieties of what has been called strophulus and infantile papular and papulo-vesicular urticaria.

**Resumé.**—The reform proposed in 1886 by E. Vidal has thus in part succeeded, but it seems to us proper in order to avoid confusion and so as not to provoke useless discussion to lay aside the nomenclature which he adopted. His polymorphous lichen mitis corresponds to the artificial lichenoid eruptions developing in predisposed subjects. His polymorphous lichen ferox is Hebra's prurigo. His acute lichen simplex should enter into the dermatological classification, but somewhat modified; it corresponds to our prurigo simplex acutus. Now the morbid series of prurigo simplex comprises :

1. Prurigo simplex acutus, the prototype of the group.
2. Prurigo simplex subacutus.
3. Prurigo simplex chronicus (typical forms).
4. Prurigo simplex chronicus (atypical forms).

His chronic lichen simplex should equally enter into the dermatological classification, but in conceiving of it as we have indicated it is better to give it the name of *névrodermite circonscrite chronique*. Quite alongside of this morbid form we should admit a diffuse neurodermitis characterized from an objective point of view by abortive lichenifications.

L. BROcq.

Paris.

## Society Transactions.

### NEW YORK DERMATOLOGICAL SOCIETY.

#### 229TH REGULAR MEETING.

DR. C. W. ALLEN, *President, in the Chair.*

**A Case for Diagnosis.**—DR. J. A. FORDYCE presented a patient, a young man, who last July was struck in the right axilla by a ball. One week afterwards a tumor developed about where he was struck, and this has been steadily increasing in size. It is a mushroom-like excrescence, about the size of an English walnut, pedunculated, and bleeds readily on irritation. Dr. Fordyce had made a diagnosis of sarcoma.

DR. G. H. FOX considered the case one of sarcoma. He called attention to the fact that in mycosis fungoides the lesions, although usually sessile, may be pedunculated.

DR. C. W. CUTLER also regarded the lesion as sarcomatous. He recently had a very similar case under his observation. The growth protruded from the lower jaw; it was pedunculated, mushroom-like and soft.

DR. S. LUSTGARTEN said the case impressed him as one of sarcoma. A tumor located in the axilla as this one was would naturally become pedunculated through the force of gravitation.

DRS. JACKSON, ELLIOT, LEWIS, SHERWELL and ALLEN also regarded the case as one of sarcoma.

**The Principles of Antisepsis in the Treatment of Eczema.**<sup>1</sup>—DR. H. G. KLOTZ read a paper on this subject.

DR. E. B. BRONSON said he has long held the opinion that certain micro-organisms play a very important rôle in eczema. It is doubtful, however, whether they are the primary factors in the disease. In order to develop eczema there must be a peculiar tendency of the skin to it, and in many persons this tendency is absent. When it shows itself, then the micro-organisms tend to increase the extent and virulence of the lesions. When a moist or crusted eczematous lesion shows a tendency to spread peripherally, with a rather sharply defined border, and especially if it tends to heal at the center, it seems to indicate the presence of micro-organisms. In such cases antiseptic remedies will often succeed in arresting the disease when nothing else will. Reference was made to the value of aristol in this connection.

DR. SHERWELL called attention to the fact that eczema is not confined to the papillary layer of the skin, as stated in Dr. Klotz's paper. He was

<sup>1</sup> See page 99.

very much in accord with the views expressed by Dr. Bronson. As regards the use of water in eczema, he employs it constantly; the lesions ought to be gently and quickly cleansed, to remove rancid applications and exuviae, before the appropriate medication is applied.

Dr. Fox said that, in his opinion, the writer of the paper laid undue stress upon local aggravating causes, and ignored the proclivity, or the diathesis, or, as Dr. Bronson called it, the tendency to eczema. As regards treatment, the one remedy which he has found to do more good than any other application in a case of typical exuding eczema, and which is the only remedy effective in both chronic and acute cases, is the impermeable dressing of vulcanized rubber, and this is very far from being an antiseptic method of treatment. Dr. Fox said he felt certain that eczema is in a large proportion of cases of internal origin, and can be far more readily combated by general treatment of the patient than by local applications to the patient's skin. The eczematous diathesis is probably due to some functional derangement of the digestive system or of some internal organ.

Dr. G. T. JACKSON said that he was inclined to agree with Dr. Fox that eczema most often had its origin in an internal rather than an external cause, though some local irritant might seem to be the active agent in producing it. This is well illustrated by eczema of the hands in washerwomen. Very often these women will use the same kind of soap and water for years without an eczema, when suddenly an eczema will develop without any apparent change in their environment. Here there must have taken place some general change in the patient's system that furnished the plus element in producing the eczema.

As to the use of water upon the skin, it certainly was harmful in most cases of eczema. This was seen in eczematous babies whose eczemas would get well as soon as the daily use of water was stopped. It was not the water that was harmful except that it removed nature's effort at repair in washing away the delicate new epidermic cells.

Dr. ELLIOT said that eczema was a clinical form of cutaneous catarrh and not always the result of one specific cause. Some cases were purely local in origin, others were of internal causation, while in still others both internal and external factors were to be considered. He also believed that an eczema could be purely of internal origin, and secondarily become infected and the symptoms of parasitic action become apparent. He had long been an advocate of the antiseptic treatment of eczema, but he could not agree with Dr. Klotz in the choice of boric acid for that purpose, for the reason that boric acid was about the weakest antiseptic known. In regard to washing eczematous surfaces, he would entirely disagree with the reader of the paper. Hebra had made the observation years ago that such procedure was harmful in eczema, and all the speaker's experience had shown him the accuracy of Hebra's statements. He had seen cases of eczema continually aggravated by washing and relapses caused innumerable times by the use of water, and he was of the opinion that antisepsis should be obtained in some other way than by washing. It is true that there are many forms of parasitic dermatitis, which are usually included under the comprehensive title of eczema, and these may be washed with benefit. But a distinction should certainly be made between these and pure eczema, though they are both examples of cutaneous catarrh. Dr. Elliot would likewise disagree with Dr. Klotz that eczema is limited to the papillary layer of the

skin. On the contrary, the histological evidences of the disease are much more extensive and may even implicate the entire cutis.

DR. LUSTGARTEN said that, as the result of clinical observation, we are entitled to assume that there are various sources of eczema. There is the parasitic variety, the toxic variety and (probably) a neurotic variety. As regards the antiseptic treatment of the parasitic variety of eczema we can, at least for the present, not speak of an antiseptic method as we do in surgery. Fürbringer and other German authorities have shown how difficult it is to disinfect even the normal skin. Furthermore, in this parasitic variety of eczema we probably have to deal with a number of different germs, and a remedy that answers in one case will, as experience shows, prove inefficient in the next. Eczema is not a clinical entity. Undoubtedly a number of remedies, valuable in the treatment of eczema, like tar, pyrogallie acid, salicylic acid, nitrate of silver and many more, have strong antiseptic properties; still, each one will only do good if used at the proper time and on a special form or stage of eczema. Empirism and rarely only theoretical reasoning has taught us how to use them. From this point of view, no doubt, the methods which Dr. Klotz recommends in his paper will answer the purpose under certain conditions, but as a general method in parasitic eczema they would be a failure.

DR. R. W. TAYLOR referred to the fact that in eczema there is a hyperplasia of the cells and a dilatation of the blood-vessels. The good results obtained by means of the impermeable dressing referred to by Dr. Fox are probably due to the fact that it produces an exsanguination of the vessels and hastens cell absorption; this it does through pressure. Very warm water is undoubtedly useful in some forms of eczema, acting as an astringent. Dr. Elliot is right in saying that after an eczematous lesion is skinned over water is irritating, but as an adjuvant in the course of treatment hot water applications may do good. Dr. Welch, of the Johns Hopkins University, has shown how difficult it is to disinfect the normal skin. He states that deep down in the epidermis there exists a white staphylococcus, and this probably gives rise to the stitch abscesses that often appear.

DR. ELLIOT stated that he likewise believed that in certain cases baths were beneficial, but they were such as alkaline, starch, gelatine, etc., not soap and water baths. He would refer to certain cases reported by himself some years ago, showing that eczema developed under purely local conditions. These were eczemas which arose under plaster-of-Paris dressings, and he recommended to the institution where they occurred that the skin should be made perfectly clean before the dressing was applied. This has been done ever since, and since then no cases of eczema under plaster-of-Paris dressings have occurred.

DR. ALLEN said he agreed with Dr. Elliot's remarks as to the varieties of eczema, hence parasitocides are not always indicated. The idea that the use of water is harmful in eczema is so very prevalent that many are afraid to apply water in any form of skin disease, and more harm results than if all cases were bathed. In some forms of eczema he considers the use of water beneficial, and he has treated a number of cases by means of the salt-water bath. The impermeable dressing sometimes gives excellent results; this may be partly due to the fact that it prevents the entrance of micro-organisms from without as well as to the fact, as stated by Dr. Taylor, that it reduces the hyperemia and hastens absorption.



DR. SHERWELL said eczema may be regarded as a catarrh of the skin. In an analogous catarrhal condition of the mucous membrane we know that water alone is painful and hurtful, while salt and water or borax and water is pleasant and acts as a detergent. This rule also holds good in eczema. He does not believe in keeping eczematous lesions dirty. They should be gently washed—not scrubbed—daily, if necessary.

DR. LUSTGARTEN said that in many cases of eczema the application of water is beneficial. Even Hebra, who is very much opposed to the indiscriminate use of water, recommends the tar bath in some forms of chronic eczema. The speaker also referred to the cleansing properties of fatty applications to the skin, rendering the use of soap and water unnecessary. Before soap was known, oil was generally used for this purpose, for instance, by the old Greeks and Romans.

DR. FOX said that in the majority of cases of dry eczema, ablution does good, while in the exuding and crusting form it is harmful. As regards the etiology of the disease, he is of the opinion that every case of eczema is of internal origin. After the internal cause has ceased to exist, the lesions are amenable to local treatment alone. He has never seen any positive proof adduced that there is such a thing as a purely parasitic eczema. It is possible, as Dr. Bronson said, that the microbes from without may modify an eczematous lesion, producing the circinate areas of the disease, but these, also may be due to a neurotic element. In reply to Dr. Elliot he said that an ordinary dermatitis may appear under a plaster bandage, but not a frank eczema, unless the patient has the eczematous diathesis.

DR. ELLIOT inquired what was the difference between an eczema and a catarrhal dermatitis?

DR. ROBINSON believes that the term eczema as at present used does not represent a clinical entity. He uses the word "eczematous," making it equivalent to a catarrhal dermatitis, a condition which can be produced by many agents acting either from within or from without upon the papillary layer and rete. The eruption in scabies and ringworm is as much an eczema as a catarrhal dermatitis from toxic substances, as seen in gout, etc. As our knowledge of eczematous inflammation increases we will gradually diminish the number of cases diagnosed as eczema, as has already been done in ringworm, scabies, seborrhœal eczema. But for the present we should include all cases of catarrhal dermatitis of indefinite origin as eczematous, but not as examples of a special disease of eczema, as that does not exist.

DR. KLOTZ, in closing the discussion, stated that he had intentionally avoided the question of the etiology of eczema, because it had no relation to the purpose of his paper. He had not considered the parasitic nature of eczema nor antiparasitic treatment, but had pointed out certain conditions incidental to and present in eczema, which were favorable to septic infection of the skin, therefore invited and demanded antiseptic treatment, and were benefitted by the same. He was far from denying that eczema in many instances is due to internal causes, to some derangement of the functions of the body, or to a certain disposition, but in practice he did not find as much of a scientific basis to work upon as others apparently did. On one point only he had taken sides, that suppuration was not essential to eczema, but the consequence of a secondary infection.

In regard to the participation of the deeper layers of the cutis in the eczematous process, Dr. Klotz said he ought to have stated that, as a rule,

only the papillary portion was affected. He conceded that the entire cutis might be affected, but only in chronic cases where conditions of a more secondary nature existed.

The impermeable dressings mentioned by Dr. Fox he would, like Dr. Allen, accept as antiseptic remedies, as they afforded protection against infection. He insisted, however, that they must be applied only after a thorough cleaning and disinfecting of the affected parts, as otherwise they were dangerous and favorable to the resorption of septic material. He had actually observed in several instances, where rubber gloves had been used without such precautions that severe phlegmonous processes involving the subcutaneous tissue of the hand and arm had occurred.

It was perfectly true that, theoretically, we cannot enforce an absolute, ideal disinfection of the skin even in its healthy condition, but that was no reason why we should not do it as well as we can. Many antiseptic remedies in practice gave much better results than could be anticipated from theoretical investigations, and in many instances effects were reached which were not borne out by laboratory tests. This was particularly true of boric acid. Dr. Klotz was well aware that it was one of the weakest antiseptic drugs, still in practice its results were excellent, and it deserved to be applied, notwithstanding theoretical scruples.

DR. KLOTZ read a letter from Dr. Manchester of Oneonta, N. Y., received in response to a question put at the 223d meeting of the Society, in which he reported the observation of poisonous effects following the external application of chrysarobin in a case of parasitic sycosis.

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## THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY. STATED MEETING, TUESDAY

EVENING, JANUARY 9, 1894.

DR. R. W. TAYLOR, *in the Chair*.

**Syphilitic Exostosis of the Frontal Bone.**—DR. F. TILDEN BROWN presented a patient, a young man, who acquired syphilis about six and one-half years ago. He does not remember having had any eruption or glandular enlargement following the appearance of the initial lesion, although he suffered from headaches and sore throat. He had no treatment at the time, thinking the disease would “wear out.” Two or three months after the disease was acquired the man married. His wife’s first pregnancy resulted in a miscarriage; the second child was born dead; the third child lived for some months—possibly a year. His wife is now pregnant for the fourth time. The man presents a syphilitic exostosis of the frontal bone. He has never had any pain connected with it, which is rather peculiar, as these exostoses are usually very painful, particularly at night. Another interesting point in connection with the case is the attempt at symmetry, a somewhat similar lesion being present on a corresponding portion of the frontal bone of the opposite side. It is a question, Dr. Brown said, whether the early treatment of syphilis has any effect in preventing a lesion of this character.

DR. GEORGE E. BREWER said that to him the swelling on the man’s

forehead did not have the feel of a bony growth; it was not sufficiently firm and hard, and he was inclined to regard it as a gumma.

DR. C. W. ALLEN said he regarded the growth as an exostosis.

DR. J. A. FORDYCE referred to the case of a woman who had a sarcoma of the breast; later on nodules appeared on the frontal bone, which was probably osteo-sarcomata of metastatic origin, presenting a similar appearance to the tumors in the case presented. He was inclined to agree with Dr. Brewer as regards the diagnosis in the case presented by Dr. Brown.

DR. JAMES P. TUTTLE also agreed with Dr. Brewer. He thought the swelling was probably due to periosteal thickening rather than to a growth of bone. The question could be easily settled by the introduction of a needle.

DR. R. W. TAYLOR said that these swellings found in syphilis—the favorite locations of which are the frontal bone and the subcutaneous surface of the tibia—are the result of a proliferation of the periosteum, and in their early stages they do not tend to have the hardness of an exostosis; as the disease grows older, the bone itself becomes involved, and then we have those hard, ivory-like masses. In a growth that has only reached the size of the one presented it is almost impossible to lay down lines of demarcation. Dr. Taylor said he had no doubt that the lack of treatment in this man's case was responsible for the appearance of this late specific manifestation. If intelligent, active, persistent treatment is commenced at the onset of the second stage and faithfully continued, syphilis can be cured, which means a shortening of the secondary stage and prevention of the tertiary stage.

DR. TAYLOR also referred to the precocious nodes not infrequently met with in syphilis. In one case coming under his observation the patient had twenty such nodes on his head; these developed between the sixth and eighth month of the disease.

DR. BROWN said he had felt rather doubtful whether to present this case as one of syphilitic periostitis or exostosis. He was glad to learn from Dr. Taylor that there is a certain stage in which it is difficult to classify these outgrowths.

**Gangrene of the Scrotum.**<sup>1</sup>—DR. C. W. ALLEN read a paper on this subject, and presented a number of drawings in connection with it.

DR. FORDYCE referred to the value of bacteriological investigations in trying to arrive at the etiology of gangrenous affections. In the case reported it was certainly due to some form of bacillary infection. Traumatism may act as a predisposing cause, by affording a means of entrance for the pathogenic microbes. Cases of gangrene of the penis produced by the colon bacillus have been reported. We have no evidence that the streptococcus can produce gangrene. In certain forms of gangrene of the skin, Dr. Fordyce said, he has found bacilli, though not the streptococci.

DR. BROWN referred to a case of gangrene of the glans penis that had come under his observation recently. The patient had a tight prepuce. The gangrene first appeared as a small, dark spot just behind the corona glandis; it was very painful and spread rapidly, at one time threatening to destroy a considerable portion of the glans. The man being unwilling to

<sup>1</sup> See page 55.

have circumcision performed, the prepuce was split up and immediate improvement followed, although the process of repair went on slowly. The surrounding inflammatory process began to subside and the bottom of the ulcer took on a healthy appearance and gradually healed entirely. Dr. Brown said he looked up the literature on this subject at the time, and was struck with the utter lack of information as to the cause, or presumable cause of gangrene of the glans penis.

DR. THOMAS H. MANLEY said he did not regard the etiology of gangrene in various parts of the body of very much consequence, nor did it seem clear to him how the study of micro-organisms would throw much light on the subject. He referred to two cases of gangrene of the scrotum coming under his observation, one of which was due to a perineal abscess and the other to a traumatic rupture of the urethra. Both patients died from general constitutional infection. In the case narrated by Dr. Allen, the disease was probably either of trophic or traumatic origin. The man was a heavy drinker; he abused himself and might have sustained an injury. The reparative powers of the scrotal tissues were well illustrated by the drawings shown by Dr. Allen. Dr. Manley said that about a year ago he saw a case of sloughing chancre which had eaten away the entire prepuce and loosened the skin from the corpora cavernosa so that it could be pushed back nearly to the symphysis, leaving the body of the penis exposed; the glans was also involved, the ulcerative process having destroyed a considerable portion of its substance. Amputation was at first advised, but upon further consideration conservative measures were employed, which resulted in recovery with a very good penis.

DR. EUGENE FULLER referred to cases of hemorrhagic infarction of the testis reported by an English observer. In these cases the scrotum swells and becomes bluish in color; it does not become gangrenous, although the testicle may. They were supposed to be due to thrombosis of the pain-piform plexus. Nash has called attention to numerous cases of gangrene of the testis due to torsion of the cord and generally in connection with partially descended testis. Nash recently reported the case of a young man who was seized with an agonizing pain while playing foot-ball; the epididymis of one testicle was found in front, and Nash, suspecting torsion of the cord, tried to untwist it, which made the boy much worse. He then pushed the epididymis behind the testicle; it remained there and immediate relief of pain followed. He regarded this as one of those rare cases of torsion of the spermatic cord.

DR. TAYLOR referred to cases of gangrene of the scrotum occurring in Bright's disease. Too much emphasis cannot be laid on the statement that conservative measure should be employed in the treatment of gangrenous affections in this locality. It is astonishing how rapidly and to what an extent the scrotal tissue reproduces itself. Any suppurative disease about the loins, particularly in alcoholic subjects, or in those suffering from Bright's disease or diabetes, is liable to produce gangrene of the scrotum. Dr. Taylor said he did not think the case reported was one of the emphysematous variety of gangrene, or malignant œdema, which spreads rapidly and is very fatal. In one such case coming under his observation the affection came on after an operation for the relief of a strictured urethra. The scrotum became purplish in color and swelled until it attained the size of a man's head, the rest of the body being proportionately enlarged.



DR. BROWN inquired whether Dr. Allen attached any particular importance to the peculiar dark, red color of the skin of the groin, to which he referred in his paper.

DR. ALLEN said he emphasized the appearance of the surface lesion because it was so peculiar that when he first saw the case he regarded that wound as the possible source of infection. It did not resemble an ordinary bubo. When the gangrenous mass gave way and the external sheath of the tunica vaginalis was exposed, it had just about the same color. He regretted that careful bacteriological investigations had not been made in this case. Still, from a practical point of view, he agreed with Dr. Manley that it does not make much difference whether it is one or half a dozen different bacilli or bacteria which produce gangrene. The various forms of gangrene, probably, have different bacilli associated with them; whether in a causative relationship or not he did not know.

DR. BROWN then narrated the history of a case in which he stated he had been unable to arrive at an exact diagnosis. It was a case of genito-urinary disease, probably involving the kidney; possibly also the bladder and urethra.

DR. FULLER gave the history of case of renal calculus, with hydronephrosis, in which there was no tenderness over the affected kidney, the symptoms being mostly referred to the testis on that side.

The following officers were elected for the ensuing year: Chairman, Dr. L. Bolton Bangs; Secretary, Dr. James R. Hayden.

## Selections.

### Therapeutic Notes.

in ent of *precocious malignant syphilis*  
Fournier recommends local treatment after removing pus and scabs with boric acid ointment or lotions until the lesions are thoroughly antiseptic. The superficial ulcerations are to be covered with mecurial plaster and the dressings changed daily. He does not use mercury internally at once, preferring to wait until tonics, good food and rest have built up the system. No iodide of potassium should be given, but when improvement begins, in general, mercury may be administered, preferably as the protoiodide combined with opium. If the lesions are numerous covering each with the plaster will be sufficient.

In the treatment of *chronic eczema* of the palms and soles Wickham softens the epidermis by poulticing, then applies a thick layer of soft potash soap for twenty-four hours; or a mixture of green soap, oil of cade and sulphur, equal parts, or salicylic or pyrogallie ointments. The irritation is soothed and the process repeated. Mercurial plaster, used in the same way, is of benefit.

JAMIESON, in the obstinate form of *indurated acne*, after opening the subcutaneous abscesses, obtains excellent results from the use of Unna's salicylic and creosote plaster, closely applied to the entire area. He uses ichthyol varnish (one part ichthyol to three of water) to abort furuncles. (*Brit. Journ. of Derm.*, January, 1894.)

A. DAMIENS (*Thèse pour le Doctorat en Médecine*) finds that injections of *ichthyol* in aqueous solution (.03 gramme to 1.0 gramme) are of service in

the treatment of zoster, lessening the pain and inflammation. The injection should be made at the periphery of the patch.

When *seborrhœic eczema* becomes universal, Unna has the patient put on at night a woollen garment soaked in a wash basin half full of water containing, for adults, five grams of resorcin and for children two grams, and wrap himself up between blankets. During the day the following ointment is applied :

R	Zinci Oxidi	parts vi
	Sulphuris Præcipitati	" iv
	Terræ Siliceæ	" ij
	Adipis Benzoati	" xxviiij

M. Sig : Pasta.

Regarding *gallunol*, MM. CAZENEUVE and ROLLER have reached the conclusion that is an active reducing agent on the skin, antiseptic and microbicidal, but not toxic like pyrogallie acid. In eczema, it quiets itching, stops exudation and causes rapid drying of the surface. It is useful in psoriasis of moderate intensity especially of the scalp and exposed portions, but not in an old and rebellious case, for there chrysophanic acid acts better. Administered by the stomach or injections, it has little toxic quality, though when introduced into the blood current it kills by its reducing action. It is an excellent microbicide, especially serviceable in favus, trichophytosis and other maladies produced by vegetable parasites.

LAUGHLIN (*Virginia Medical Monthly*) has employed *thiol* in eczema of the nares, the upper lip, the scalp, in intertrigo, furunculosis, malignant pustule, acne, rosacea, etc. It has all the advantages of ichthyol without its odor, irritant quality and tendency to soil everything with which it comes in contact.

JOHNSTON.

#### Treatment of Acute Orchitis by Carbolic Spraying. THIÉRY AND FOSSE. (*Gazette Méd. de Paris.*)

The sick man is placed in position as if for the passage of a speculum, his thighs, belly and buttocks covered by a rubber cloth, the testicle only exposed. An atomizer should be used which will permit of raising or lowering the temperature and continuing the sittings for a sufficient length of time. The jet should be placed at a distance of ten centimetres, and the temperature should be 37° C, continuing the spray for twenty to thirty minutes. It should be repeated two or three times a day, the patient remaining in bed in the intervals. With a 1-20 solution, the epithelial desquamation will be abundant ; with a 1-50 solution it will take place. This should be the strength used with infants. The spraying quiets the pain and inflammatory symptoms.

JOHNSTON.

#### Urinary Neurasthenics. PROFESSOR GUYON. (*Journal de Médecine Pratique*, June 10, 1893.)

Urinary neurasthenics constitute an important category of patients whose two principal symptoms are these : they complain on the one hand of difficulties in micturition ; on the other of pains which they refer to the bladder. They are far from being rare ; they have almost always diurnal polyuria. In half the cases the jet is feeble, and an effort is necessary to produce it ; the jet ceases when the effort fails to sustain it ; it stops so short

hat it seems to indicate the presence of a calculus. These patients suffer, not because of a desire to urinate, but aside from micturition; their sexual appetite is feeble; their nervous symptoms are very characteristic; more than three-fourths of them present pharyngeal anæsthesia.

Urinary neurasthenies are generally young; they often have hereditary or personal antecedents; examination of the urine shows, the majority of the time, its perfect integrity. The bladder empties itself completely. Examination of the canal is difficult because of its extreme sensitiveness. In conclusion, these people showing nervous phenomena of the genito-urinary passages, must be considered as having no true disease. If they have no appreciable anatomical lesion they have at least an irregularly acting nervous system and certain functional derangements easy to demonstrate.

JOHNSTON.

**Subcutaneous Injections of Salt Solution, Employed as Diuretics, Particularly in the Treatment of Albuminuria of the Puerperal State.** PORAK AND BERNHEIM. (*Nouvelles Archives d'Obstétrique*, May 25, 1893.)

It has been demonstrated, by experiment, that the use of chloroform determines a sometimes abundant, transitory albuminuria. Therefore, chloroform can not be employed without danger in combatting the symptoms of puerperal eclampsia. The purgatives have too slow and too short an action. Diaphoresis is subject to the greatest possible objections.

In the treatment of albuminuria it is important to insure the renal function either in curing the lesion itself or in maintaining the function. The first is very difficult; the maintenance of the function can be brought about by the use of diuretics; these are often toxic; it must then be determined whether diuresis cannot be produced by introduction of water into the organism.

The authors have used water with the addition of seven and one-half grammes of chloride of sodium to the litre (a .75% solution). It is necessary to inject abundant quantities—590 to 1,000 grammes at one time. The greater the quantity injected the greater the assurance of diuresis. One thousand five hundred grammes of liquid can be injected in eight hours by four injections.

Six observations complete the work. In the first, the quantity of urine, which was nihil, was carried in twelve hours to 500 grammes; for the twelve hours following to 600, for the next twenty-four, to 1,200 grammes, where it was maintained for three days, falling afterward to 1,000. Observation II. They injected 1,300 grammes in two sittings. Observation III. Urine 750 grammes after first injection of a litre, then reached 1,200 grammes. This result was obtained in the other cases, varying only slightly in the figures.

This question, though treated by the authors from a special point of view, enters nevertheless into the therapeutics of albuminuria in general and into the use of diuretics in cases of nephritis other than puerperal.

JOHNSTON.

**A Case of Pustular Scrofulide.** ARTHUR STANLEY. (*Brit. Jour. of Derm.*, November, 1893.)

The patient, a boy of fourteen, with a family history of tuberculosis and manifestly scrofulous himself (having a purulent discharge from the ears and suppurating cervical glands) gives a history of a recurrent erup-

tion, the period of activity beginning in the Spring, accompanied by an exacerbation of the tubercular process in the neck. Profuse sweating was also present. The lesions forming the eruption were multiform; small, isolated papules not grouped; small, conical, thickly crowded papules, pin-head in size with a central horny spine; larger, rounded papules, surrounding a hair; vesicles capping the last; pustules following the vesicles, scabbed papules; papules with scab rubbed off presenting a central pit caused by evulsion of a sebaceous plug; pigmented spots; minute cicatricial pits (one-twentieth of an inch in diameter). Individual elements were watched and discovered to pass through the successive stages from the small grouped papules to the cicatricial pits. The lesions were found on the lower part of the face and abdomen, scapular regions, extensor surfaces of the arms and forearms, the thighs, buttocks and legs. They were not grouped in the manner of lichen scrofulosorum. No tubercle bacilli were found.

JOHNSTON.

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## Book Review.

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*Electricity in Diseases of Women and Obstetrics.* By FRANKLIN H. MARTIN, M.D. W. T. Keener Company, Chicago, 1893.

The volume is one of the second edition of the work which has been revised and considerably enlarged by addition of four new chapters. The subjects of these chapters are General Galvanization and Faradization; the Electric Bath; Static Electrotherapeutics; and Summary of Treatment of General Diseases, thus giving the work a wider scope than was originally intended, including the application of electricity in all diseases except those falling to the specialist as in eye and ear and disorders of the male generative system.

The older portion of the treatise is subdivided into two parts. The first is occupied with the principles of electricity, its laws and facts. All forms of apparatus useful to the electrotherapist are described, and, what is better, illustrated by numerous plates and cuts with accompanying keys. One chapter is devoted to the selection of currents to fit a given case. The second division treats of the application of the principles enunciated to the treatment of disease, the proper form of apparatus for use in each case, with minute directions as to the application. Authors are prone to take much for granted in the question of detail in procedure, but that fault cannot be found in this book. Every step is carefully explained. While one may not share the author's enthusiasm in his subject and may incline to skepticism on the question of the results obtained, as, for example, in cancer and stricture, he must still admit that the case presented is a strong one and if the directions are as carefully followed as laid down many a good result will be obtained. Apostoli's treatment, as would be expected, occupies the most prominent place, a whole chapter being devoted to the author's successful cases, treated by his modification of the method. In the next, he considers the reasons for failure in the cases where failure occurs. There are few, if any, of the diseases, peculiar to women which may not be benefitted by one form of electricity or another. The chapter on the treatment of hysteroneurasthenia is particularly commendable.

J. C. J.



# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

### A CASE OF VARICOSE LYMPHANGIECTASIA—LYMPHATIC CAPILLARY VARICES.

BY

GEORGE T. ELLIOT M.D.,

Dermatologist to Demilt Dispensary ; Assistant Visiting Physician to the New York Skin and Cancer Hospital ; Professor of Dermatology, New York Post-Graduate Medical School, etc.

**L**OUISA W—, female, age thirty-nine, a native of Canada, was kindly referred to me in November, '92, by Dr. A. Brayton Ball. The patient stated that there had not been any consumption or particular disposition to disease in her family. She had herself never been robust in health, but subject to bronchitis and transitory attacks of swelling of the face and feet without demonstrable cause—possibly attacks of angioneurotic œdema. Her functional health had always been fair, beyond a slight tendency to constipation. In childhood she had suffered severely from what is generally termed “scrofulous” adenitis; the anterior and the lateral cervical, the inframental, supra-sternal and right axillary glands having become successively affected. These had broken down and suppurated, discharging externally, and after a certain time they had healed, leaving marked cicatrices. At the age of fifteen, her left eye had been removed for some undescribed inflammatory process.

On being examined, the patient was found to be not particularly well nourished. She was wrinkled and worn, and gave the impression of being some years older than she was in reality. On the neck a number of scars were seen, which formed a

broken chain along the anterior borders of the sterno-mastoid muscles and extended under the chin. Similar cicatrices were present in the supra-sternal notch and in the right axilla. Some were superficial and non-adherent, others were deep, puckered and bound down and pigmented, all, however, bearing the impress of scars resulting from tubercular glands, which, secondarily infected, had undergone suppuration and opened externally. The patient could not remember how long after the formation of these scars the lesions for which she sought relief had originated. They were constituted by more or less large groups and chains of vesicular discrete efflorescences, located in the neighborhood and along the edges of the cicatrices over the lateral surfaces of the neck, especially on the right side, and also over the upper portion of the sternum, just below the supra-sternal notch, and along the posterior border of the right axilla. The individual lesions were of various sizes, some so minute as to be visible only with a magnifying glass, but the majority, however, about pinhead size. Apparently none were seated deeply in the skin. They were all prominent and rested upon the surface like drops of yellow dew, being tense and not rupturing easily. On pressure, they diminished in size, even disappearing altogether in the axilla, and refilling only slowly after removal of the pressure. The skin upon which they were seated was not thickened, reddened or changed in any way. No telangiectases or blood-vessel dilatations were present. No subjective disturbances were complained of, but the woman stated, and her statement was verified by observation, that when one of the vesicles ruptured, either spontaneously or accidentally, a steady trickling of a pale straw-colored fluid ensued and continued for hours, and even days. This took place particularly from the lesions just below the supra-sternal notch, the amount of the discharge being sufficient to saturate the patient's linen.

After excision of a portion studded with vesicles from the posterior border of the axilla, the patient was subjected to treatment. The individual lesions were separately punctured with a fine needle attached to the negative pole of a galvanic battery, and it was then pushed into the skin successively in various directions. A moderately strong current of electricity was used. Some of the vesicles were destroyed by one treatment, but the majority, and especially those around the supra-sternal notch and the axilla, required several applications. They were, however, finally all destroyed, but whether permanently

or not, I do not know, as the patient has not been seen since February, 1893. The portion of the skin excised was hardened in alcohol, mounted in celloidin, and after sections were made they were stained with borax-carmin and hæmatoxylin.

The stratum corneum was practically unchanged. The rete was unimplicated, except in connection with certain of the vesicular formations, as will be referred to presently. There was no thickening of the corium, or any vascular changes, but in its papillary and subpapillary portions in the vicinity of the vesicles, there was a slightly marked cellular infiltration. The especial features seen were cavities of variable size and configuration situated superficially and at various depths in the cutis (Figs. 1, 2, 3, 4 and 5). They were unilocular, though in certain

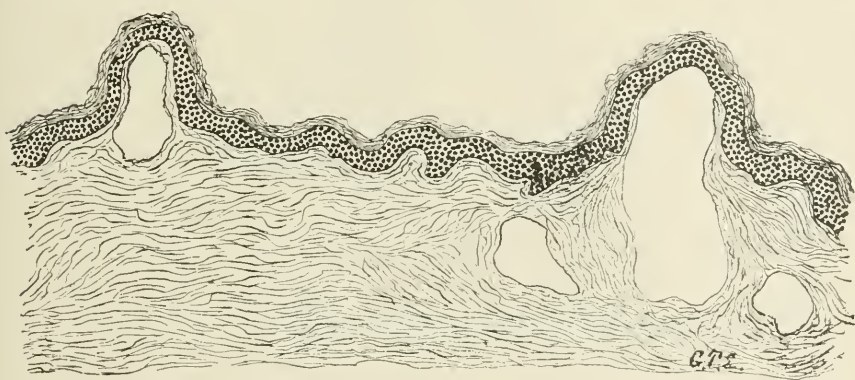


FIG. 1.

SECTION THROUGH TWO OF THE VESICULAR ELEVATIONS, SHOWING THEIR  
RELATIVE DISTANCE FROM EACH OTHER.

ones fragments of possible septa could be seen. As a rule, simple, some were arranged linearly, suggesting a tortuous vessel cut at various levels (Fig. 2). The cavities were lined by a single layer of endothelium, which was continuous in the majority (Figs. 1 and 2), but in others it was wanting in places, and they were bounded by slightly dense connective tissue (Fig. 4), or by the rete alone (Fig. 3). The cavity formation was most marked in the papillary portion of the cutis and corresponded here to the vesicular lesions objectively seen. They projected considerably above the level of the surrounding skin, occupying a single or several contiguous papillary spaces. The papilla was distended and enlarged in the majority, and the cavity was separated from the external surface by a layer of

connective tissue, the rete and the stratum corneum (Figs. 1 and 2). In others, however, only the two latter constituted the outer boundary (Fig. 3), the endothelial lining having disappeared at the point of contact. In certain of the vesicles, the basic layer of the rete was also absent, and the outer wall consisted of the stratum spinosum, which in some had ruptured, and allowed the contents of the cavity to escape externally. The ruptured ends were not ragged, but smooth and rounded. The contents of the cavities were granular, amorphous matter.

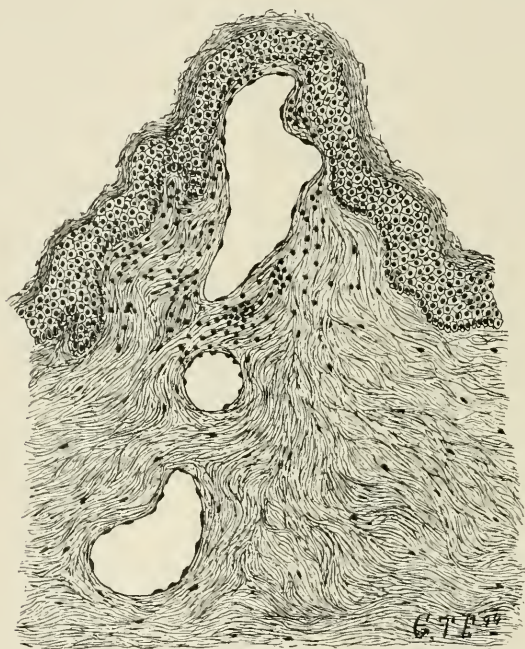


FIG. 2.

LINEAR ARRANGEMENT OF CAVITIES IN CUTIS, SUGGESTING A VARICOSE  
VESSEL CUT AT DIFFERENT LEVELS.

In some of the papillæ capillary blood vessels could be seen running alongside of the cavities, but no communication between them could be made out, nor were any blood-cells seen in the contents of the dilated lymphatics.

Nothing of importance was found in connection with the appendages of the skin, except that portions of the coils of some of the sweat-glands had undergone cystic degeneration, and cystic dilatation had also occurred in the course of their ducts.



The vesicular formations objectively seen in this case were thus found to consist of lacunar dilatations lined with endothelium and situated in the upper portions of the cutis. Their morphology, the absence of any blood-cells or constituents in their contents, and the discharge of lymph for hours and days even, after intentional or accidental rupture, would locate them in the lymphatic system, but I would, however, regard them as the result of simple lymphangiectasia, rather than lymphangioma, owing to the entire absence of any plexus, or evidences of new formation of lymph vessels or spaces. Besides, the

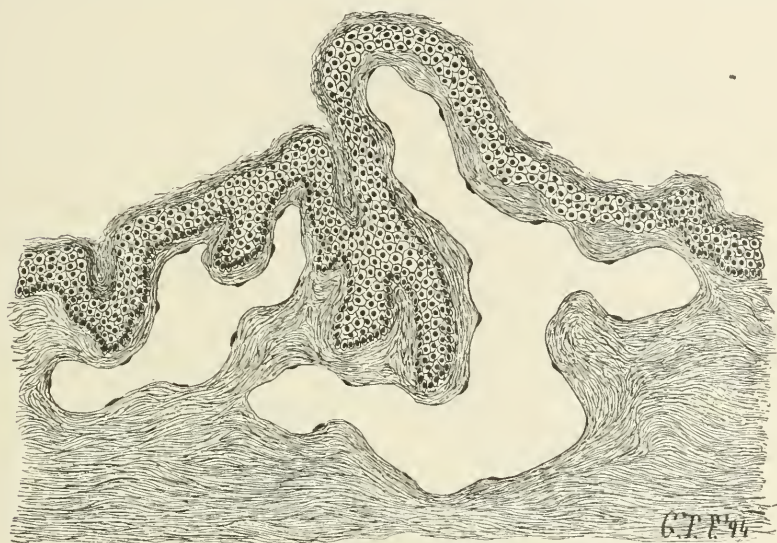


FIG. 3.

VERY LARGE LACUNÆ OCCUPYING SEVERAL PAPILLÆ.

dilated channels were few in number, were separated by wide areas of entirely normal cutis (Fig. 1), while those which were contiguous were so arranged in relation to each other that the suggestion was given that they were parts of one dilated space cut at various levels (Fig. 2). The origin of this capillary lymphangiectasia does not appear to me to be obscure, owing to the lesions being grouped only around and about the cicatrices due to the suppuration and destruction of the glands. This location would strongly suggest that their development was caused by a mechanical obstruction to the lymph current or by the obliteration of efferent lymph vessels.

The case possesses some additional interest owing to its clinical resemblance to lymphangioma circumscriptum, of which a number of cases have been reported and which has received very careful study at the hands of Török and Noyes, and more recently of Francis. In fact, until sections of the tissue were examined, I regarded it as an example of lymphangioma circumscriptum and similar to another case reported by me in 1891. Francis has grouped the cases of lymphangioma recorded in literature in four categories :



FIG. 4.

CAVITY BOUNDED EXTERNALLY BY RETE ONLY.

I. Lymphangioma simplex, consisting of a dense plexus of normal sized and walled lymphatic vessels with no alteration in the surrounding tissue.

II. Lymphangioma cavernosum.

III. Hæmatolymphangioma, or a growth made up of hæmangioma and lymphangioma.

(a) The lymphangioma developing in a nævus.

(b) The original growth a well-defined hæmangioma and a lymphangioma coexisting or developing subsequently.

(c) In which the lymphangioma is associated with dilated tufts and vascular capillary striæ.

(d) In which there were no hæmangioma *en masse*, nor capillary tufts, but increased redness, or excess of pigmentation in affected area.

IV. Lymphangioma associated with localized elephantiasis.

When we compare the clinical and microscopical features of my case with the characteristics of these classes and subclasses of Francis, it is evident that the necessary factors are wanting

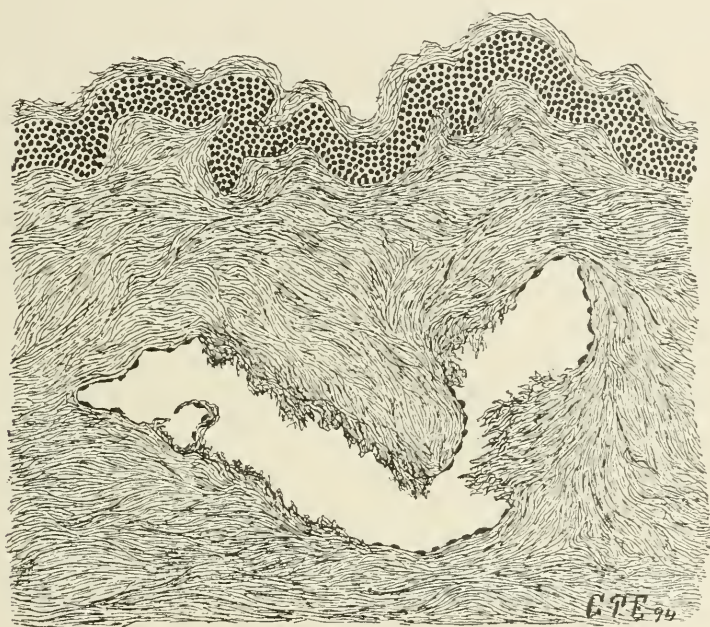


FIG. 5.

LARGE CAVITY IN SUBPAPILLARY PORTION OF CUTIS

which would allow it to be included in any one of them. The absence of any plexus formation of normal sized and walled vessels in the cutis would exclude it from Group I., while II. would not come under consideration, nor would IV., owing to the absence of pachydermia or elephantiasic change in the affected areas. There were no clinical evidences or facts suggesting that the lymphatic changes had developed upon a nævus, or in connection with a hæmangioma; there were no capillary tufts or striæ, or redness, or pigmentation associated with them, nor



microscopically could any connection be made out between the blood-vessels and lymphatic spaces, nor did the latter contain either blood-cells or hæmatic constituents, and in consequence Group III. and its subclasses could also be excluded. The case is therefore recorded as one of simple varicose capillary lymph-angiectasia.

## REMARKS ON CHRONIC URETHRITIS.<sup>1</sup>

BY

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**F**EW subjects have been so exhaustively discussed as chronic urethritis, yet it is still justifiable to thresh over the old straw in search of a few germs of practicality which may have been overlooked. Even though new material may not be found, known facts may be presented in such a manner as to add to their value. I shall not endeavor to discuss the subject of chronic urethritis exhaustively, as it would prove too much for your patience. As a reward for my generosity, I trust that you will pardon some heresies which I am likely to perpetrate.

*Etiology of Chronic Urethritis.*—Under this head it would only be necessary to outline the various causes of acute urethritis due to infection or otherwise, were it not for the fact that chronic urethritis may occur independently of an acute attack, and even where the chronic follows the acute form its development is likely to result from secondary causes.

The causes may be tabulated as

- |                      |                        |
|----------------------|------------------------|
| 1. Acute urethritis. | Gonococcal.<br>Simple. |
|----------------------|------------------------|

Acute urethritis alone cannot be responsible for the super-vention of the chronic stage. Other factors are necessary, such as

- |   |  |
|---|--|
| (a) Diatheses and constitutional disorders. | Tuberculosis.<br>Struma.<br>Syphilis.<br>Gout.<br>Rheumatism, and any general disease which lowers nutrition or produces irritating properties in the urine. |
|---|--|

<sup>1</sup> Read before the Chicago Pathological Society, December 12, 1893.



(b) Local irritants and excitants of hyperæmia and functional activity.

*Such as*

Alcoholism.  
Highly nitrogenized diet.  
Excessive use of tobacco.  
Over-exercise.  
Sexual excitement without gratification.  
Coitus.  
Masturbation.  
Injections acting both mechanically and chemically.  
Instrumentation.  
Soluble bougies.

(c) Friction and mechanical interference with the outflowing urine, pathological secretions produced by

Stricture, congenital or acquired.  
A narrow meatus.  
Tight dressings.

(d) Sources of auto-infection.

Folliculitis.

The importance of diathetic conditions cannot be overestimated. Gout and rheumatism are very important factors for consideration, lithæmia being of especial importance. Tubercular disease in its incipency bears a very important relation in some cases to chronic urethritis. Simple anæmia and debility are not to be ignored. In these modern days of antiseptic practice we are apt to forget some very valuable therapeutic notes gathered by the wayside by our medical forefathers.

Syphilis may be questioned as a cause of chronic urethritis, unless distinct lesions exist. The association of chronic urethritis and syphilis is so close in many cases, however, that one cannot wonder that our forefathers believed in the unity of gonorrhœa and syphilis. Either chronic urethritis is sometimes perpetuated by syphilis or syphilis often follows urethritis in cases in which no chancre can be discovered. That syphilitic patients with gonorrhœa are especially liable to stricture of the urethra I firmly believe. It must be remembered that diatheses may act in one of two ways, or both, viz.: (1) by producing a lessened resistance, *i. e.*, local debility of the mucous surfaces; (2) by so disturbing the relative proportion and qualities of the solid matters of the urine as to produce highly irritating properties in that fluid. Obviously, our remedies must be aimed at a target which is at once general and local.

It is unnecessary to say much in this presence of alcoholism as a factor in the production of chronic urethritis. I would state, however, that our patients are seldom convinced of the necessity for prolonged abstinence. Personally, I believe that

no patient should take a drop of liquor of any kind for from three to six months after an apparent cure of gonorrhœa or urethritis.

Can alcohol cause chronic urethritis? I believe it can. Given an irritable mucous membrane, the more damaged the better, and alcoholic excess is apt to develop primarily a sub-acute urethritis, and if long-continued, a chronic type.

Tobacco is not generally regarded with suspicion, but I am positive that its excessive use acts as an irritant to the genito-urinary mucous membrane.

Dietetic errors necessarily dovetail with the gouty diathesis. Imperfect digestion, still faultier assimilation and defective elimination of crude metabolic products come into play. This is at once obvious. We are prone to be of a local turn of mind in treating gonorrhœa, and forget the skin, stomach, and, worst of all, the bowels.

Sexual excitement, however produced, is to my mind the chief cause of chronic urethritis. Unrest is the keynote to the etiological problem in all cases; this unrest may, it is true, be due to occupation or over-zealous treatment, but sexual excitement—mental or physical in origin—is always present. Remove the factors of disquiet, and gonorrhœa would be no more to be dreaded than any other acute inflammation—complications, however, receiving their due meed of respect.

Relapses in the course of an acute gonorrhœa are most often due to some source of disquiet, usually sexual. Deeper acute infection may explain relapses, but this is itself usually due to sexual excitement, liquor, or over-exertion. Every relapse means increased resistancy to cure and increasing danger of chronic urethritis.

Treatment by instrumentation is often ill-advised, and is responsible for chronic inflammation. Soluble bougies are still more open to impeachment, as they not only act mechanically, but often chemically. Acute gonorrhœa is a *noli me tangere* as far as the introduction of mechanical sources of unrest and irritation is concerned. Soluble bougies and the catheter are often responsible for the conveyance of infection to the deep urethra. Injections properly used are often a source of great benefit, but I believe that more harm than good is wrought by them on the average. It would be a blessing if injections were universally tabooed in the acute stages of a gonorrhœa. I trust that issue may be taken with this assertion in the discussion, as there are some points which may be brought out that are hardly in keep-

ing with the object of this paper, but upon which I would gladly expatiate. In a general way I find that the proportion of complications and of terminations in chronic urethritis is in direct ratio to the vigor of attempts to check the disease. Medical students who treat themselves are great experimenters, and in 80 per cent. of cases present serious complications. Private patients and the overflow from "stampers out" of gonorrhœa show a wide difference in the proportion of complications and succeeding chronic conditions. I find that the ratio of accidents is 10 to 1 greater in the victims of the stamping out process. Gonorrhœa can be best cured by the slowest route. Ricord once said that "anybody could tell when a gonorrhœa started, God alone knew when it would end." The average results of those who try to cure a gonorrhœa in a hurry would puzzle even Ricord's court of last resort. Much has been recently said of the rôle of posterior urethritis in a chronic gleet and relapsing gonorrhœas, but I am still following in the wake of Otis in the belief that mechanical conditions in the anterior urethra are by far the most important factors in the production of gleet. I shall not stop here to consider whether chronic urethritis causes stricture, or *vice versa*, excepting to say that both of the warring factions are right. I will say, however, that in 90 per cent. of cases of intractable gleet the cause lies in the anterior urethra. If the posterior urethra be involved it will still be found that the anterior portion of the canal is diseased. I wish at this juncture to state positively my conviction that in every case of gleet there exists disease of the anterior urethra, whether the posterior urethra be diseased or not. Pus or muco-pus escaping from the meatus never comes from the posterior urethra. I wish to call attention here to the pernicious custom of obstructing the outflow of pus from the urethra in gonorrhœa by tight dressings. Many a case of deep infection is due to this faulty drainage.

Folliculitis is often a cause of chronic urethritis. Very often a hair-like sinus or fistula is left in the urethra, which perpetuates the trouble indefinitely. I often see these just within the meatus, and I infer that they may exist elsewhere in the canal. Coitus or even violent excitement may open an infected follicle and cause a pseudo-autogenetic gonorrhœa. Posterior urethritis has of late been made responsible for all of the chronic ills of the urethra—a very comforting theory for those to whom urethrotomy is a *bête noir*. Just here I wish to place myself on record as believing that, as between the dangers and inconveni-

ences of urethrotomy in competent hands, and those of indiscriminate tinkering of the posterior urethra, the odds are largely in favor of urethrotomy.

A word as to the frequency of posterior urethritis as a sequela of gonorrhœa. I do not think it is so frequent as is usually believed. Pray consider what proportion of our patients have vesical symptoms or epididymitis in the course of gonorrhœa—I say vesical symptoms for the sake of clinical distinction. The trouble is rarely vesical, but the symptoms are decidedly so. The proportion of such cases is decidedly small. I will now state that when patients with gleet present themselves to me I draw a broad line of distinction between the cases in which there has been no posterior involvement and those in which it has taken place by the history as regards vesical and testicular symptoms. If such symptoms have been absent throughout I infer that the posterior urethra has not been invaded—at least to the extent of a primarily acute infection. If such symptoms have been present I infer that posterior inflammation has not only occurred but is still present in greater or less degree. Once infected with gonorrhœa, always diseased is my axiom in respect to the posterior urethra. If this be disputed I will simply say that the disputant has not studied the prostatic urethra and its environments very carefully.

A point regarding the rationale of posterior infection: extension by contiguity may occur, but it is very often produced by infection through the medium of injection fluid. Soluble bougies, catheters and sounds must bear their share of the burden. A mode of infection not suggested by any of the authorities with which I am familiar occurs during coitus or nocturnal pollutions. During the orgasm, the prostate, membranous urethra and surrounding muscles act precisely like the bulb of a Davidson's syringe—there is an alternate compression and expansion which results in alternate expulsion and suction of fluid. In clearing itself of fluid the deep urethra draws such excess as may remain in the anterior urethra back into its lumen, whence a final convulsive effort or series of efforts finally expels the entire quantity. As the fluids of the diseased anterior urethra are drawn back into the deep urethra germs are drawn in and infection results. I believe that this suction action has much to do with the contraction of acute gonorrhœa primarily.

For diagnostic purposes, the urine drawn in two glasses is sufficiently accurate. If the second glass be clear I do not



think we should waste much time worrying over the posterior urethra. Another point: gleet is being treated everywhere by deep urethral injections, when the sole trouble is in the anterior urethra. Sooner or later the diagnosis becomes justified, if the operator be active with his deep syringe. I again reiterate the assertion that a discharge from the meatus never comes from the posterior urethra. If the tonic contraction of the veritable sphincter of the bladder, *i.e.*, the membranous urethra, will prevent the escape of urine during the intervals of micturition, the scanty amount of pus, formed in posterior urethritis, is not likely to escape from the deep urethra.

*Treatment of Chronic Urethritis.*—Increasing experience tends to confirm me in the belief that the somewhat arbitrary position taken by Otis some years ago regarding the necessity of anterior internal urethrotomy, in by far the greater proportion of cases of gleet, is justified by the fact that the more I see of chronic urethritis, the more confident I become that internal urethrotomy in the anterior urethra is well nigh a specific. I do not, however, recommend the routine practice of urethrotomy in every case of chronic urethritis, even where distinct coarctations are evident in the anterior urethra. I am well aware of the fact that some cases in which large-calibred strictures are present recover without operation, and I am inclined in a certain proportion of cases to give the case the benefit of the doubt and try other means of treatment before proceeding to more radical measures. I confess, however, that when I do make the attempt to avoid the operation, I am apprehensive of disappointment, and accordingly warn the patient of the probable necessity of an operation later on. When a case presents itself to me with a history of prolonged urethritis, which has been treated by a number of other practitioners, some or perhaps all of whom are thoroughly competent men, I am inclined to delay operation. I am fully aware under such circumstances that my predecessors in the management of the case have rung all possible therapeutical changes. I feel, moreover, under such circumstances that it would be presumption on my part to suppose that the ordinary remedies will act any better in my hands than they do in the hands of the numerous others who have treated the case before me. In cases of this kind I am in the habit of advising urethrotomy. I think it may be accepted as a good rule in practice that the treatment of prolonged chronic urethritis should embrace as a preliminary measure the removal of all coarctations in the anterior urethra. Whenever

the patient objects to operation he should be informed that all other measures are of the nature of a compromise. Internal urethrotomy does not always cure chronic urethritis, even in cases in which strictures of greater or less calibre are the cause of the chronic urethral inflammation. But it must be acknowledged that in many cases, while other treatment than urethrotomy may be necessary and perhaps very valuable, it is rarely of great benefit until after urethrotomy has been performed. Chronic inflammation, localized in the bulbo-membranous region, or in the prostatic urethra, requires topical applications. The most popular method consists of the application of solutions of nitrate of silver of varying strength by means of the Ultzmann syringe, or some of its modifications. To read the brilliant disquisitions upon the treatment of chronic urethritis which are to be found in some of our text-books and in the majority of medical journals' articles upon the subject, one might be led to suppose that the deep urethral syringe is little less than a magician's wand in the subjugation of posterior urethritis. With a few injections the urethral expert charms away gleet which have been standing so long that the memory of the patient runneth not to the contrary. I am almost ashamed to confess what most certainly seems to be due to a lack of skill on my part, *i.e.*, that in my hands the deep urethral syringe has been somewhat disappointing. I cannot obtain the extraordinary results which some of my brethren claim. I do not wish to be understood as condemning the deep urethral syringe, for properly used it is a measure of great value.

A word as to the style of deep urethral syringe. The Ultzmann and its modifications impress me as homœopathic weapons against a profound pathological process. These syringes hold but a few drops of fluid. It is impossible to flush the deep urethra thoroughly with an antiseptic solution by means of the Ultzmann deep urethral syringe. I have had constructed a syringe holding about half an ounce; with this instrument I find that it is perfectly practicable to flush the posterior and anterior portions of the urethra quite thoroughly. I find also that with this instrument I get much more positive effects from solutions of nitrate of silver of relatively feeble strength than seems to be possible with the ordinary form of Ultzmann syringe.

The systematic passage of steel sounds is still one of our main reliances in chronic urethritis. It must be remembered, however, that attempts at stretching a urethra which contains

distinct coarctations—if they be resilient—usually result in aggravation of the inflammation. I find in some cases that the occasional passage of the exploring bulb is of great value simply from its alterative effect upon the diseased mucous membrane investing slight urethral coarctations.

By far the best method of treatment of chronic urethritis, both anterior and posterior, is by means of copious antiseptic irrigations *via* the short urethral nozzle. These solutions may be varied in strength and composition. I find their relative value to be about as follows: (1) Permanganate of potassium, (2) nitrate of silver, and (3) bichloride of mercury. Bichloride of mercury by irrigation has not fulfilled my anticipations. The permanganate of potassium has proven extremely valuable, as also has the nitrate of silver. It may be found useful to alternate the two last, the permanganate being used in the strength or from 1-5,000 to 1-15,000. The nitrate of silver should be used in a strength of from one-half to one per cent. A more pronounced effect can be obtained from this strength of solution of nitrate of silver, when used by deep irrigation by means of the short urethral nozzle, than from relatively strong solutions used by means of the deep urethral syringe. There is no difficulty in by far the majority of cases in flushing the deep urethra by means of the short urethral nozzle. After a few *séances* the patient is usually able by his own intelligent co-operation to assist us in a very marked degree. The constitutional treatment of chronic urethritis is of the greatest importance, as might be inferred from what has already been said upon the relation of gout, rheumatism, syphilis, and general debility to the disease. Measures to correct the rheumatic, gouty, and syphilitic diatheses are often absolutely essential. Where syphilis exists I believe it to be rational practice to put the patient on a mild anti-syphilitic course. No matter what system of treatment may be advised, it will be found that certain cases are practically incurable. I believe, however, that in most of these if continence and abstinence from dietetic indiscretions be persisted in for a prolonged period the disease will finally subside. In some cases I have come to believe that the time element, with absolute cessation of treatment, is the best possible procedure that can be advised. Unfortunately, however, this is a plan of management with which the patient can rarely be made to sympathize. He is willing to rest a sprained joint, or a broken limb, or perchance an irritable stomach and bowel, but to rest a lame urethra is to him quite another mat-

ter. This fact is the explanation in my opinion of the apparently intrinsic stubbornness of many cases of chronic urethritis. In the stubborn cases in which I have succeeded in convincing the patient that prolonged rest was likely to be more beneficial than any form of treatment, I have almost invariably had reason to be gratified with the result. In any stubborn case, I am of the opinion that absolute cessation of treatment for a prolonged period is often highly beneficial, and measures of treatment which have been previously entirely ineffectual may act almost magically when treatment is resumed after a prolonged period of rest.

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A CONTRIBUTION TO THE PATHOLOGY OF ACNE VARIOLIFORMIS HEBRÆ.<sup>1</sup>

BY

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AS neither the pathological anatomy nor the ætiology of acne varioliformis have to any extent been investigated, and as some confusion exists regarding the connection of the lesions with the hair follicles or glandular apparatus, I have taken this opportunity to present to the Association the results of some work done by myself, which I offer as a small contribution to the pathology of the affection. In 1891, under the title of "*Acne Varioliformis of the extremities*" (JOUR. OF CUTAN. AND GEN. URIN. DIS., April, 1891), the clinical characteristics of an affection were described by Bronson which in many respects corresponded with typical acne varioliformis of the face. As the result of a microscopic examination by myself of papules and papulo-pustules in various stages of development, the conclusion was reached that the disease began as an inflammatory exudation about the coil glands, which later led to a generalized infiltration of the derma, and was followed by a sharply circumscribed degeneration of the affected area in the form of a dark brownish-red slough, followed by a depressed pigmented scar. The eruption disappeared under the use of local antiseptics, but the patient subsequently came under my observation at another dispensary with

<sup>1</sup> Read at the Seventeenth Annual Meeting of the American Dermatological Association September 5, 1893.



a second outbreak of the same character as the first, which again subsided under the application of antiseptic lotions.

The belief was expressed at that time that this case was identical in its clinical appearances, at least, with the better known eruption on the face. As the morbid anatomy of the latter disease was unknown, a positive opinion regarding their pathological identity could not be expressed.

In 1892 Pollitzer described an eruption under the name of "*Hydradenitis Destruens Suppurativa*" (JOUR. CUTAN. AND GEN. URIN. DIS., January, 1892), in which the lesions began as deep-seated nodules which gradually enlarged until they attained the size of a pea. Suppuration followed, and ultimately the crust covering the papule fell, leaving a depressed pigmented scar.

Anatomically, he found the process to begin at the junction of the cutis and sub-cutaneous cellular tissue. In the inflammatory exudation he found disorganized coil glands, which simulated giant cells.

The cells of the coil glands in the neighborhood of the infiltration showed parenchymatous changes, so that he was led to the conclusion that the process began as an affection of the glandular epithelium.

The case described by Dr. Bronson and myself; although presenting such marked similarity both in its clinical and microscopic appearances, was not mentioned by this writer.

An analysis of these cases, together with one reported in 1889 by Giovannini (Giornale Italiano d. Malattie Ven. e della Pelle, 1889, p. 302), the first case of the kind studied microscopically; the cases reported by Barthélemy (Ann. de Dermat. et Syph. 1, 1891) under the title of "*Acnitis*," and two observations of his own form the subject of an elaborate paper by Dubreuilh (Archives de médecine expérimentale, 1, 1893,) entitled "*Des hidrosadénites suppuratives disséminées*."

This writer carefully examined the lesions removed from his own cases, and was able to determine the origin of the process in the region of the sweat glands. He could not give a definite opinion, however, as to whether the first changes occurred in the glandular epithelium, as maintained by Pollitzer, or in the surrounding connective tissue, as my own sections seemed to show.

Dubreuilh also considered the differential diagnosis of this suppurative hydradenitis and acne varioliformis (Hebræ), which it so closely resembles in its clinical features, together with "*Acne necrotica*" (Boeck) (Archiv. f. Dermat. u. Syph.,

p. 37, 1889). The latter affection, which Dubreuilh is inclined to consider a distinct disease, cannot be definitely classified because of our imperfect knowledge of its anatomical situation, Boeck's examination in the case reported by himself being limited to the separated necrotic tissue. Of this he gave a minute and careful description, and concluded that the inflammation began about the hair follicles, rapidly extending to the surrounding tissue, and involving them in a destructive process. From the fact that Boeck's case began with the eruption on the forehead in the typical location as given by Hebra and from the anatomical seat of the inflammation about the hair follicle, I am inclined to class it, in view of my own examination of *acne varioliformis* (to be detailed later) with that disease.

Pick (Archiv. f. Dermat. u. Syph. p. 551, 1889,) makes a clinical distinction between the two affections, describing a typical case of *acne varioliformis* (Hebra) which Dubreuilh (l. c.) identifies, on the strength of Pick's description, as a case of *hydradenitis*.

Pick's anatomical examination failed to show any connection between the lesion and the sebaceous gland or hair follicles, and Dubreuilh's view of the nature of the affection is strengthened by this fact.

No microscopic examination was made in the case reported by Pick as one of *acne necrotica* (Boeck). From the foregoing it seems to be well established that there exists a suppurative inflammation of the sweat glands characterized clinically in its beginning by a deeply situated papule which gradually enlarges and produces an elevation of the overlying epidermis followed by suppuration or necrosis of the affected tissues, and resulting in a depressed pigmented scar. The eruption may be disseminated or grouped and occur on the face, body or both.

It may, like *acne varioliformis*, with which it has been confused, heal and relapse indefinitely. An attempt to find micro-organism in the diseased area has been unsuccessful, and the view has been expressed that the excretion by the coil glands of some chemical substance might be responsible for the inflammation in and about these structures. The affection described by Leucasiewicz under the name of "*Folliculitis exulcerans*" (Ergänzungs heft zum Archiv. f. Dermat. u. Syph. ii., 1891), Pollitzer believes to be a variety of *hydradenitis* after comparing the histological appearances of this affection with his own case. The occurrence of lesions on the palm of the hand, which is referred to by Leucasiewicz, would further strengthen this

view, although the colored plates which accompany his article show entirely different gross lesions.

*Histology of acne varioliformis.*—During the past Summer I excised a number of papules from two cases of acne varioliformis which were under my treatment.

In one of the cases, a female, aged about forty, the eruption was present on the forehead at the margin of the scalp and on the temples.

Superficially seated papules, papulo-pustules, lesions covered with dried secretion, pigmented scars and non-pigmented scars were present, showing an affection of some standing. The patient, in good health and well nourished, stated the eruption had been present for some years; the active lesions would occasionally disappear and return again. The second patient was a Hebrew, aged sixty, in whom the eruption was confined almost exclusively to the hairy scalp. The vertex was bald, produced in part by the disease, evidences of which in the presence of cicatrices existed over the bald region and also on the forehead.

The eruption was in active progress over the lateral boundaries of the scalp and behind the ears, as shown in the photograph. (Fig. 1.)

A careful observation of the papules in the early stage of their development showed that they were superficially seated in the derma and not, as in hydradenitis, in the subcutaneous tissue. The majority of the lesions were perforated by a hair.

Before the occurrence of suppuration or the destruction of the epidermis, the changes consist of a dense, round cell infiltration about the hair follicles, generally above the situation of the sebaceous glands. (Fig. 2.) In some of the sections the sebaceous glands are surrounded by the exudation, while in others they are quite free. The coil glands are normal and outside the inflammatory zone.

As the process extends the infiltrations spreads in a lateral and upward direction, involving the papillary and subpapillary areas. The cells of the outer root-sheath become disintegrated and infiltrated with exudation cells, and finally all the layers of the follicle may be invaded and destroyed by the inflammatory process.

The upper half of the hair follicle may be destroyed by the intensity of the inflammation, while below the follicle and sebaceous glands appear almost normal. (Figs. 3 and 4.) The secreting cells of the sebaceous glands resist the action of the

disease for a considerable time and present a normal appearance later than the surrounding connective tissue. The cellular infiltration in the affected area was readily stained with hæmatoxylin and carmine in marked contrast with the exudation in hydradenitis which showed early in its course a tendency to degeneration. The separation of the affected tissue *en masse* by a process of dry necrosis was not so marked a feature of the microscopic picture as in hydradenitis.

The papules from the face of the woman first mentioned were removed at an early period of their development and failed to show any tendency to early necrosis. In the scalp sections the destruction of the epidermis and underlying tissue which constitute the final stage of the process, was not sharply circumscribed, the inflammatory exudate gradually shading off into the neighboring tissue. The pathological changes in the epidermis covering the papule, which take place from below upwards, consist in a vacuolation of the rete cells with little ability to take the hæmatoxylin stain. The horny layer is sometimes found separated from the cells beneath and finally the entire epidermis disappears by process of liquefactive degeneration.

In both the scalp and face sections numerous longitudinal sections of hair follicles were met with, so that it was not difficult to detect the seat of the first changes in the affection.

*Micro-organisms.*—Sections taken from an early papule of the face (female) and stained by Kühne's carbolic-methylene-blue solution showed the presence of enormous numbers of staphylococci contained within the lymph vessels and free in the tissues. These organisms were especially numerous about the middle and deeper portions of the hair follicles within the external and internal root sheaths, in the connective tissue about the coil glands and in the subcutaneous connective tissue. In the papillary layer of the derma and in the older parts of the infiltration the organisms are much less numerous. Their number, distribution and appearance before the lesion had involved the epidermis rendered their etiological relationship to the disease very probable. In a secondary infection they would not be found at so early a period and probably in fewer numbers.

The distribution of the micro-organisms in question suggested that they had gained entrance to the tissues through the hair follicles, exciting a reaction in the derma after being taken up by the blood or lymph vessels.

The more frequent occurrence of the affection among those



in the lower walks of life and its localization in the majority of instances on the forehead, exposed to pressure by unclean hat bands, would lend some weight to the theory of a local infection.

Sections from the second case (male) were stained in the

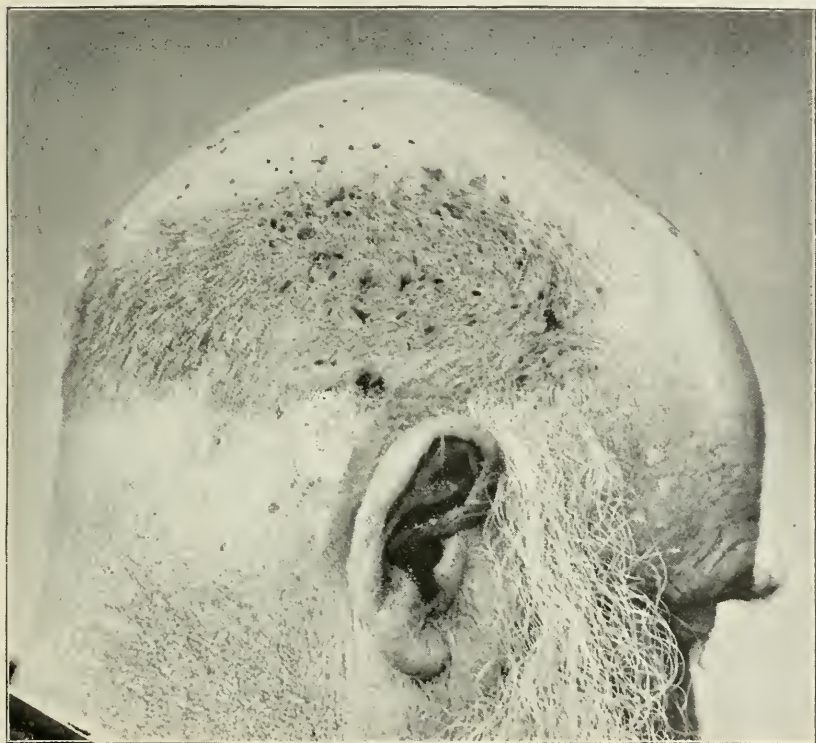


FIG. 1.

ACNE VARIOLIFORMIS OF THE SCALP.

same manner as those just mentioned and also by Gram's and other methods, but in no instance were organisms of any kind discovered.

Thinking some fault existed in the technique the procedure was repeated a number of times with a like negative result.

The lesions in this case being older it is possible that the staphylococci were taken up by the leucocytes or destroyed in

other ways, leaving only their effects, or their presence in the other case may have been purely accidental. The lesions in both cases healed rapidly under an ointment containing sulphur and naphthol.

As such close clinical resemblances exist between acne vari-



FIG. 2.

SECTION OF A RECENT PAPULE IN ACNE VARIOLIFORMIS SHOWING DENSE ROUND-CELL INFILTRATION ABOUT HAIR FOLLICLE. X 200.

oliformis and hydradenitis the penetration of the pathogenic organisms in the one case through the hair follicle and in the other through the sweat ducts might explain their microscopic differences.

In substance it may be stated that acne varioliformis (Hebra)

is an inflammation of the pilo-sebaceous system, probably microbic in origin, leading to destruction of these organs and the surrounding derma, and that Bazin was correct in naming the disease acne pilaris.

Touton (Verhand. der Deutsch. Dermatol. Gesellschaft, Zweiter und Dritter Congress) reported with microscopic examination a case which clinically corresponded with Boeck's acne

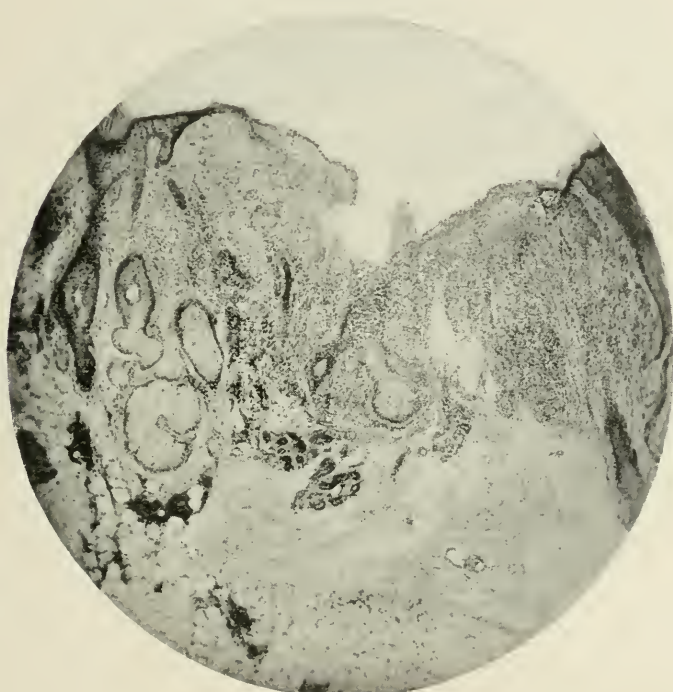


FIG 3.

AN OLDER PUSTULE FROM ACNE VARIOLIFORMIS SHOWING DESTRUCTION OF  
DERMA AND EPIDERMIS. X 25.

nerotica. The eruption had existed for more than a year and was present on the face and breast. The patient was addicted to the excessive use of alcohol.

Touton found that the inflammation began about the middle and deeper portions of the hair follicle and was followed by a partial degeneration of the affected area and dry necrosis.

In the upper layers of the necrotic tissue and in the hair



follicle he found staphylococci and other micro-organisms, and in the hair itself bacilli of different dimensions.

He expresses no positive opinion in reference to the etiolog-



FIG. 4.

A MORE HIGHLY MAGNIFIED VIEW OF HAIR FOLLICLE AND SEBACEOUS GLAND FROM FIG. 3.  
THE UPPER PART OF THE FOLLICLE IS DESTROYED. X 200.

ical relationship of the organisms to the disease but rather leans to the view that their presence was accidental.

Leloir and Vidal, from an imperfect examination of two old lesions of acne varioliformis (acne rodens), believed the seat of the pathological process to be about the hair follicle and sebaceous glands, their situation in the sections being outlined by embryonic cells.

The "Ulerythema Acneiforme" of Unna (International



Atlas of Rare Skin Dis. 1) which is classed by Besnier with this acne group, differs from acne varioliformis by the absence of central necrosis, suppuration and ulceration, by the presence of cornedones and the form of cicatricial atrophy which does not suggest small-pox scars (Unna).<sup>1</sup>

## CASE REPORTS.

BY

B. MERRILL RICKETTS, M.D.,

Cincinnati, Ohio.

**S**MALL, round and spindle-celled sarcoma. Miss —, æt. 53, white, maid, German, in a fair physical condition, referred to me by Dr. Wm. H. Falls in October, 1888, with a discolored growth upon the abdomen, about six inches to the right of the median line, and about two below the umbilicus. This growth had existed as a simple papilloma for many years, causing no trouble whatever. Some time during July, 1888, she noticed that the growth became discolored, and that there was a slight elevation of the same color about the growth. Dr. Falls had removed the growth by means of a ligature about this time, and it was thought that it would not return. However, within three or four weeks she noticed that there was a recurrence and that the pigmented circle about the growth was gradually becoming elevated and darker. Her general health at this time did not seem to be interfered with. My diagnosis was a sarcoma of a most malignant nature, and I also advised that the growth be removed in toto, especially as I desired a piece for examination microscopically. About November 10th, under the influence of cocaine subcutaneously, I took out a piece of the integument about five inches long and about three inches wide. (Fig. 1.) Primary union was secured, so that there was but little inconvenience experienced from the operation, but little more than would have been had the growth alone been removed for examination. At the conclusion of the microscopical examination I stated to the members of the family and her physician that it was a small, round and spindle-

<sup>1</sup> Kaposi in the last edition of his book and also in Archiv. für Dermat. u. Syph. Heft. 1, 1894, has described several new varieties of acne (Folliculitis), one of which, "Acne necroticans et exulcerans serpiginosi uasi," presents some points of similarity with Leucasiwicz's folliculitis exulcerans. In this case the papules began as circumscribed infiltrations in the deeper parts of the corium and were accompanied with numerous giant cells.

celled sarcoma, and that she would, in all probability, die within six months. There was no other indication at this time of the presence of the disease; however, within sixty days small nodules were noticed scattered here and there over the entire body, extremities, head and neck. They gradually grew in size and



FIG. 1.

number. The glands of the neck by this time were gradually becoming involved. She was cachectic, began to lose her appetite, and experienced a tired feeling. Her temperature ranged from  $99^{\circ}$  to  $100^{\circ}$ , and she gradually lost flesh. Morphine and opium were resorted to for the relief of pain, and were taken

quite frequently as the disease became more manifest. I saw her occasionally, advising her attendants to give her all the opium necessary to make her perfectly comfortable. During the latter part of January she was compelled to keep her bed, where she remained until about the 10th of February, when she died. Her mind was very much affected during the last sixty



FIG. 2.

days of her life. Although granted an autopsy, I was not allowed to do anything more than open the abdomen. The mesentery was filled with nodules, varying in size from a millet seed to a quail's egg, and was generally adherent to the walls of the abdomen and viscera therein contained. There was a great amount of bloody serous effusion in the abdominal cavity.

*Syphilitic ulcer—Rhinoplasty.* Miss —, colored, æt. 21, referred to me during the spring of 1888 by Dr. B. K. Rachford. Fair physical condition; small lesion appeared upon the tip of nose right at the median line, about three years previous. This gradually increased in size until the entire upper lip and nasal alæ were covered with a phagedenic ulcer, having somewhat the characteristics of an epithelioma, for which it had been treated by several physicians. (Fig. 2.) Although there could be found no history of either hereditary or acquired syphilis, I gave one-quarter of a grain of protiodide of mercury after each meal. At the end of twenty-five days the crusts were gone and the ulcer healed. I advised a plastic operation, which was consented to. The right nasal cavity was almost obliterated. About this time I found cicatrices upon the mother, which was sufficient evidence to me that the daughter was suffering from hereditary syphilis. After several months of treatment I decided to take a flap from the upper arm and restore the parts as best I could. This was done and the arm placed in position over the head with straps, that the union might not be interfered with. The flap became adherent, and the primary operation was all that could be asked for. While preparing for the secondary operation, she was taken with typhoid fever, and died at the end of the twenty-first day. —*The Trinidad.*

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## Society Transactions.

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### NEW YORK DERMATOLOGICAL SOCIETY.

#### 230TH REGULAR MEETING.

DR. C. W. ALLEN, *President, in the Chair.*

#### **A Case of Keratosis Follicularis.**—Presented by DR. ALLEN.

The patient was a young man suffering from torticollis. Scattered over his back were small, disseminated inflammatory lesions, follicular in character, and from the center of the follicles little projecting spines, about one-sixteenth of an inch in length, could be seen by oblique light. The spines could also be felt by passing the hand over the skin. Dr. Allen said he had diagnosed the case as one of keratosis follicularis. Over the rest of the body the patient had a mild keratosis pilaris. An interesting feature in connection with the case is that when a hypodermic injection is given a peculiar erythema will develop, sharply defined about the region where the injection was made.



DR. GEORGE T. JACKSON said that from present appearances he would diagnose the case as one of keratosis pilaris. The projecting spines referred to by Dr. Allen seem to be absent.



DR. FOX'S CASE OF LYMPHANGIOMA. THIS PHOTOGRAPH WAS MADE BY DR. PIFFARD AT THE MEETING, WITH THE ARC LIGHT, AS REFERRED TO LATER.

DR. JOHN A. FORDYCE regarded the case as one of keratosis follicularis.

**A Case of Lymphangioma.**—Presented by DR. GEORGE H. FOX. The patient was a man aged 60 years, a farmer, with a lymphangioma of the

right arm and forearm, and of the clavicular and sternal region on the right side. The trouble was first noticed in 1865, after an injury to the collar bone. A vesicle appeared below the clavicle; this contained a turgid fluid and gradually developed into a solid gelatinous mass. The lesion slowly extended over the chest and right arm. Tumors formed from time to time; some of these became the seat of an inflammatory process, which slowly subsided, leaving well-marked cavities behind. The affected region presents a pronounced elephantiasic appearance. (See cut.)

DR. FORDYCE said the case impressed him as being one of some form of infection, possibly tubercular. The swelling of the arm was probably due to growth of connective tissue which, by pressure, interfered with the return flow of the lymph. He would await the result of a microscopical examination before venturing a more positive diagnosis, but would certainly not consider lymphangioma as the primary affection.

DR. GEORGE T. ELLIOT said he had seen the patient at St. Luke's Hospital two or three weeks ago, and had then made the diagnosis of connective tissue and lymphatic tuberculosis, the so-called scrophuloderma, as described by many German and French writers. In its mode of origin, progress, etc., it is very similar to tuberculosis of lymphatic glands. So far as lymphangioma is concerned, he did not see the slightest ground for such a diagnosis in this case, for the reason that lymphangioma does not ulcerate. In the patient just presented the tendency to ulceration was evidently very marked, and an important factor in the process, judging by the amount of cicatricial tissue seen.

DR. SHERWELL said he thought there was a lymphangiomatous element in the case. The ulceration might have been caused by irritating applications, or perhaps there was a secondary tubercular infection.

DR. P. A. MORROW referred to the eczematous condition of the right forearm. It also presented a swollen and lymphangiomatous character which he has not observed in any form of tuberculosis.

DR. ELLIOT said the swelling of the arm was probably the result of the interference with the lymphatic circulation. In every form of disease in which the lymphatic vessels are affected this condition of dystrophy occurs, and in such cases, a catarrhal inflammation could easily be produced by any number of causes. In the case presented the subcutaneous trouble had existed for over twenty years, and the eczematous changes were, no doubt, a secondary complication. He saw no connection between it and the original trouble.

DR. SHERWELL referred to one place under the deltoid of the patient presented in which there were decided evidence of fluid, and this fluid was, apparently, not pus, but in his opinion retained lymph. He consequently thought this resembled a lymphangiomatous rather than a scrofulous process.

DR. ELLIOT said it was not necessary to have pus in scrophuloderma; that was the result of secondary infection. The production of cyst-like formations, such as were felt in the lymphatic vessels along the arm, might be due to an impediment offered to the lymphatic circulation, and by implication of the lymphatic vessel itself in the process.

DR. FOX said that from a purely clinical standpoint he would certainly pronounce the case one of lymphangioma. The location of the disease, its long duration, the formation of tumors and its clinical characteristics

generally seem to correspond very closely to cases of lymphangioma that have been reported by others. He did not know what the exact pathological process was that had been going on underneath the skin, but its clinical appearances certainly entitled the case to the name lymphangioma.

DR. ELLIOT said he has never met with or heard of any case of lymphangioma cavernosum undergoing spontaneous ulceration and breaking down. There is such a thing as a tubercular lymphatic infection, which may result in ulceration and breaking down, but that is not a lymphangioma. True lymphangioma, whether it is cavernous or superficial, does not ulcerate unless it has been subjected to traumatism, etc.

DR. PIFFARD referred to a case of lymphangioma coming under his observation in which ulceration had occurred. The lymphatics were very much enlarged and the surface presented a rugose appearance. Considerable fluid was withdrawn by puncture. The secretions were not examined for filaria.

DR. ELLIOT said that if we call a dilatation of the lymphatics from obstruction or from any disease a lymphangioma, then we may see ulceration occur, but if we use the term according to its strict surgical definition then ulceration does not occur as a complication.

#### **A Case for Diagnosis.**—Presented by DR. CONDUCT W. CUTLER.

The patient was a young man with a marked hypertrophy of the lower lip. The process began three years ago last Winter as an eczematous condition of the lower lip, below the vermilion border, and since then the lip has steadily increased in size. The condition becomes slightly improved during the Summer, and worse in Winter. The man has a tubercular process going on at the apex of the right lung.

DR. FORDYCE said the hypertrophy was probably due to lymphatic obstruction.

DR. R. W. TAYLOR referred to a somewhat similar case that he presented to the Society twenty-two years ago. The patient was a young Irish boy who had an hypertrophy of the upper lip fully two inches long. There was also some swelling of the upper lip. There was no history of erysipelas. The boy had asthma, and died suddenly of heart disease shortly after he came under observation. Dr. Taylor said that these cases of hypertrophy of the lip, developing in early adult life, are rare. They differ from the cases of swelling of the upper lip seen in scrofulous children. The case, with comments, was published in the *Medical World*, November, 1871.

DR. CUTLER said that during the past three years the lip had never recovered its normal size. In Winter it was two or three times larger than in Summer. He thought there was probably some relation between ordinary local œdema and this general hypertrophy of the lip. In one other case that had come under his observation there was for over a year a condition of local œdema of the lip, recurring every two or three months, sometimes more frequently. After this had recurred a number of times the œdema remained permanent.

**The Treatment of Xanthoma by Means of Electrolysis.**—DR. FOX presented two patients treated in this way, with very good results. The first patient was a man with patches of xanthoma on the upper and lower eyelids, which rapidly disappeared after two introductions of the needle. In

the other case a patch of xanthoma on the upper eyelid of a woman entirely disappeared after the needle was introduced five times very superficially and held for a minute. A current of one and one-half to three milliamperes was employed. The operation causes very slight pain.

DR. ELLIOT said he had treated two cases of xanthoma of the eye-lids by means of electrolysis with very satisfactory results, the results of this method of treatment in xanthoma being as good as in fibromata, warts, and other small growths of the skin.

DR. SHERWELL considered electrolysis an improvement on excision in the treatment of these cases. In the patients presented the current appears to have exerted an escharotic rather than an absorbent effect on the lesions.

DR. PIFFARD said we do not get absorption in electrolysis, excepting as a secondary result. When the negative needle is used we simply get electrical disassociation. With the positive needle we get a different result, but in neither case do we get absorption directly from the operation. Absorption of the disintegrated products may occur as a secondary result. An interesting little experiment in this connection is to take the white of an egg and place it in a small beaker; the two needles are then inserted into it, and a current of from two to ten milliamperes passed through them; at the end of five minutes, if the needles are withdrawn and examined, a dense coagulum will be found around the positive needle, while the negative needle will simply be covered over with frothy bubbles.

DR. FORDYCE said he has never treated xanthoma by means of electrolysis. In rosacea he has found that method of treatment satisfactory in some cases.

DR. ALLEN referred to a case of keloid of the breast which he is at present treating by means of electrolysis. About one-half of the lesion has been destroyed, and from the present appearance a permanent cure may be anticipated.

DR. FOX said he has employed electrolysis in a considerable number of cases of xanthoma. Formerly he employed excision to some extent. In the two cases presented the treatment was so simple and so rapidly performed, and the result was so successful, that he was inclined to regard electrolysis as preferable to any other method. The application of the thermocautery, acids, etc., will remove patches of xanthoma by destroying the tissue. In electrolysis we have a destructive agent that is perfectly under our control; there is no danger that the destructive process will extend beyond the limit we desire to have it go.

#### A Case for Diagnosis.—Presented by DR. CUTLER.

The patient was a young woman, 22 years of age. She was perfectly well until her fourteenth year, when she had an attack of measles. Following this a tumor, as she expresses it, appeared on the right forearm, just below the elbow. This disappeared on treatment received at the University Medical College. It afterwards returned and gradually increased in size, extending up the arm, until now it reaches almost to the shoulder; it also extended downwards almost to the wrist. It occasionally gives rise to some pain, but is more annoying on account of its size and appearance. It is of irregular shape, uneven surface and dusky red color, as though composed of dilated veins, and has a soft, boggy feel. The surface is studded with a



large number of sebaceous follicles, from which sebum can be pressed. There are several similar but much smaller growths on the trunk and extremities.

DR. ELLIOT regarded the lesion as a *nævus mollusciformis*.

DR. MORROW agreed with Dr Elliot's diagnosis.

**A Case for Diagnosis.**—Presented by DR. CUTLER.

The patient was a young man, 28 years old. Three months ago a number of small tumors developed immediately beneath the man's skin. They vary in size from a pea to a horse-chestnut and are soft to the touch. They first made their appearance on the arms in almost symmetrical positions; afterwards on the trunk. Those on the extremities give rise to no pain, but those on the trunk are quite painful, particularly one on the back and another almost directly over the apex of the heart. There are about twenty or thirty of these tumors in all.

DR. ELLIOT made a diagnosis of lipomata.

DRS. TAYLOR, JACKSON and KLOTZ also made a diagnosis of lipomata.

DR. PIFFARD said he thought the tumors contained more connective tissue than fat. They did not have the feel of lipomata.

DR. MORROW was inclined to think there was a fibrous element in the growths. Lipomata, too, are usually not so generally diffused as the tumors are in this case.

DR. SHERWELL was inclined to regard the growths as fibro-lipoma.

DR. FORDYCE said the general condition of the patient rather favors the diagnosis of lipoma. In *molluscum fibrosum* the patients are usually more mentally enfeebled. In one case of a similar appearance coming under his observation the growths, on excision, proved to be fibro-myxomata.

DR. ALLEN diagnosticated the case as one of multiple lipomata.

DR. CUTLER said when he first saw the case he pronounced the tumors lipomata. Some of the growths, however, especially those on the body, are hard and fibrous and do not feel at all like lipoma. In only one of the tumors could multiple lobules be detected. Dr. Cutler said his own diagnosis was fibromata. He promised to have one of the growths excised and examined microscopically.

**A Case of Recurrent Desquamative Scarlatiniform Erythema.**—Presented by DR. ALLEN.

The patient was a young man who gave a history of having had a number of attacks of desquamative scarlatiniform erythema. Such an attack occurred two years ago; another one in August last; a third in October, and a fourth one, from which he is now recovering, on December 10th. The eruption has none of the features of eczema. It does not itch, and unless it is extremely irritated it does not weep. It is followed by a well-marked desquamation. The attack lasts about ten days. No albumin was found in the urine.

DR. ALLEN said a number of cases similar to this one have come under his observation. One patient, a man, gave a history of having had thirteen attacks, and since coming under observation he has had five or six more. In that case the eruption is often brought out by the ingestion of a drug, by the application of a sinapism, or by a drug locally applied; in one in-

stance it followed the use of a cream balm for catarrh. Most of these patients give a history of nasal catarrh.

DR. H. KLOTZ said that the number of attacks these patients may have seems to be unlimited. In one case which he heard reported at a meeting the patient had sixty-six attacks.

DR. TAYLOR said that in one case coming under his care, a lady aged 38 years, an eruption of this kind was brought out by the ingestion of half a grain of quinine. Another time it was produced by a quinine wash applied to the head. The desquamation is well marked in some cases.

DR. ELLIOT said that many cases of so-called idiopathic scarlatiniform erythema are called idiopathic simply because we fail to discover their exciting cause, not because they have no cause. He considered the eruption as absolutely symptomatic, the response on the part of the skin to all kinds of factors. It may be due to the ingestion or to the application of certain drugs, to food products, to exposure, to wounds, or as a prodrome of diseases. It is seen in septicæmia and pyæmia, etc.; it is not a specific eruption, but the result of a multiplicity of causes. The French would make a distinction between scarlatinoid and scarlatiniform erythema, because in the one the temperature is slightly higher, the course more acute, the intensity greater than in the other; but he could not see in such a distinction anything more than an artificial and voluntary division, which was not founded on a substantial basis.

DR. FOX said the most interesting clinical feature of this affection is its recurrence every two or three or four months. They are apparently idiopathic. They may be due to some derangement of the nervous system or to some one of the numerous causes referred to by Dr. Elliot. Anxiety or depression may precipitate an attack. In one case coming under his observation the erythema was intense, resembling closely the true scarlet fever eruption and followed by a slow desquamation.

DR. ELLIOT referred to the individual idiosyncrasy as an important factor in these cases, owing to which the patient was liable to have an attack produced by any of the above-mentioned causes, not necessarily by the same factor in every outbreak. He might also mention the influences of climate and of season among the causes of the eruption. One patient of his suffered from an attack of the erythema every year for four consecutive years, and always during the same month and very nearly on the same date.

DR. FORDYCE said that under certain conditions this form of eruption might be mistaken for scarlet fever. In a case coming under his observation salicylate of soda was prescribed for a tonsillitis, and within twenty-four hours afterwards an eruption like that of scarlet fever appeared which went on to desquamation.

DR. SHERWELL said he observed a number of these cases during one of the recent epidemics of the gripe. The erythema in those cases might have been produced by one of the synthetical drugs, many of which had been employed at that time. They did not go on to desquamation.

DR. ALLEN said the resemblance between scarlatiniform erythema and the true scarlet fever eruption is often so close that in two cases coming under his observation the patients had been treated for the latter affection. One man, who gave a history of thirteen recurrent attacks, was treated for scarlet fever by a homœopath in this city and again by a regular practitioner

in the country. In one case seen by Dr. Allen, a baby, the eruption, inflamed throat and strawberry tongue were all present, and he made a diagnosis of scarlet fever. On the third day a bogginess appeared on the child's scalp which developed into an abscess, and was opened. In that case the eruption was probably due to the shut-up mass of pus. In another case the eruption has been variously caused by the patient's taking phenacetin and salol, salicylic acid, Dover's powder and by the application of a plaster. Such attacks are always followed by desquamation.

DR. ELLIOT mentioned as one of the points of differential diagnosis between the scarlatiniform eruption and that of scarlet fever, the desquamation, which in the former begins on the third or fourth day and may be found on the flexor surfaces, even though absent on other areas while in the latter desquamation begins on the tenth or twelfth day.

**A Case of Acné pilaire cicatricielle.**—This case was presented for Dr. LUSTGARTEN by Dr. ALLEN. The condition is also known as Unna's ulerythema sycosiforme. The lesion is essentially a sycosis, followed by cicatrization. There seems to be an atrophy following the inflammatory process. In the case presented the primary lesion was a pustule, situated mostly on the bearded portions of the face. Improvement is now taking place after epilation and the use of resorcin. The man has a number of sycosis pustules on the upper lip.

DR. FOX said that the sycosis on the lip was typical, but it occurred to him from the location of the lesion at the angle of the jaw, its circular outline and the fact that it extended beyond the region of the hairs, that there might have been an erythematous lupus, which very often occurs in this region in patches of similar appearance to this; the atrophic condition and folliculitis might have developed subsequently, although he has never seen the latter occur as a result of lupus.

**A Case of Dermatitis Herpetiformis.**—Presented for Dr. LUSTGARTEN by Dr. ALLEN.

The patient was a man, a native of Sweden. The disease has existed for several years. It has some urticarial elements. The man also had some eczematous lesions, which have disappeared under treatment. At present he is being treated by pilocarpine, one-sixth to one-fourth grain every second day, which appears to act well.

**A Case of Lichen Ruber.**—Presented by Dr. FOX.

The patient was a boy who had been already presented to the Society a number of years ago. Since that time the disease had pursued its regular course, sometimes better and sometimes worse. It had never disappeared entirely. The general health of the patient has improved. The itching, which is very severe, is relieved by vaseline better than by any other application. The eruption first appeared on the arms; it then extended down over the forearms, and recently it appeared on the chest and back. The lesions here very much resemble those of psoriasis. Some of the lesions on the chest seem to be flattened on the surface from the very outset like those of lichen planus. Dr. Fox also presented a number of photographs of this case, taken in different stages of the disease and representing various clinical aspects.

DR. ELLIOT said he regarded the case as one of pityriasis rubra pilaris, and the same as the lichen ruber acuminatus of Kaposi.

DR. ALLEN also thought the case to be one of pityriasis rubra pilaris.

DR. FOX said he did not care whether the name pityriasis rubra pilaris or lichen ruber be applied to the disease. His case was identical with those shown before the Society heretofore.

DR. SHERWELL said he did not think the case presented by Dr. Fox was one of pityriasis rubra. His own case of lichen ruber was entirely different. The lesions were papular in character at all times. The disease existed for about fifteen years, when the woman died from general marasmus.

DR. PIFFARD exhibited an arc light which he had been using for some months in connection with photo-micrography and stated, of several he had tried this was the only one he had found satisfactory for this purpose. He said it also might be usefully employed for the photography of patients in the office. With the patient six to eight feet away he had found that exposures of from seven to ten seconds were sufficient. The lamp was devised by Mr. E. P. Hopkins and was now manufactured by J. B. Colt & Co., of 16 Beekman Street, this city.

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#### THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY. STATED MEETING, TUESDAY EVENING, FEBRUARY 13, 1894.

DR. L. BOLTON BANGS, *Chairman*.

**Two Cases of Multiple Chancre.**—DR. B. E. VAUGHAN related the history of a man who, three weeks after suspicious intercourse, had a chancre appear at the junction of the scrotum and penis. Four weeks later a second chancre developed on the frenum, followed in ten days by a third one at a point on the scrotum where the frenum came in contact with it. All three of the lesions were typical indurated chancres, without any chancroidal elements. A general macular eruption appeared about a week after the development of the third lesion. Dr. Vaughan also referred to another case in which a chancre developed at the meatus, followed two weeks later by a second lesion on the body of the penis, where the clothing came in contact with it.

DR. CHARLES L. GIBSON presented a specimen of cancer of the penis removed in 1883, and also the remainder of the man's genito-urinary organs, removed at autopsy ten years afterwards. The amputation of the penis was performed by Dr. R. F. Weir at the New York Hospital, in 1883. The patient was a man 73 years old. Family and personal histories negative. No history of any venereal trouble. Two years previous to the time of operation the man noticed a hard, painful nodule in the left lower aspect of the prepuce. This steadily grew until it attained the size of a chestnut. Then a small ulcer formed, which failed to heal. At the time of operation the man was well nourished and all the vital organs appeared to be normal. The entire penis, especially the distal half, was much swollen and inflamed. The glans was swollen and glazed. Upon the upper and left side of the prepuce, which was greatly enlarged, was an ulceration irregularly circular in



shape and about one and one-quarter inches in diameter. It was covered with large, soft granulations and exuded a whitish, foul-smelling puriform secretion. There was an enlarged gland in the left groin. Amputation was performed on December 1, 1883, and the man discharged cured twelve days afterwards. A microscopic examination of the growth showed it to be an epithelioma.

This patient was readmitted to the New York Hospital on December 20, 1893, and died in two days, the cause of his death being pneumonia, bronchitis, emphysema and chronic diffuse nephritis. The condition of the genito-urinary organs was carefully noted at the autopsy. The urethra was normal and there was not the slightest evidence in any part of the body of a secondary deposit or a recurrence of the tumor of the penis which had been removed ten years previously.

DR. GIBSON also narrated the history of the following case: Male; aged 43 years. Admitted to St. Luke's Hospital August 14, 1884. Family and personal histories negative. No venereal history. Sixteen months previous to his admission he noticed a small indurated mass in the skin covering the penis, about one inch from glans. A cauliflower-like excrescence projected from the inner surface of the prepuce, near its free margin. There was also a periurethral abscess. The inguinal glands on both sides were enlarged. Specific treatment having no effect, operation was resorted to. The growth on the penis was excised and the periurethral abscess opened. He left the hospital October 13, 1884, when there was still a granulating surface at the site of the excision. The pathological report made at that time stated that the warty part of the growth corresponded to the structure of warts elsewhere; the other part and the tissue at the base of the wart contained sinuses lined by epithelial cells. While not a typical epithelioma, the pathologist was inclined to give a rather grave prognosis.

This patient was again seen by Dr. Gibson at the Vanderbilt Clinic in October, 1893. He stated that four years after his original operation he had undergone a simple, circular amputation of the penis, perhaps less than one-half the organ being removed. After this he got along fairly well for about three years, when the glands in the right groin became involved. When Dr. Gibson saw him he presented a mass in this region the size of a child's head, with extensive ulcerations, the growth having the typical appearance of advanced epithelioma. The inguinal glands on the left side were enlarged to the touch. The patient died at the Cancer Hospital about December 1, 1893.

**Cancer of Penis and Groin.**—DR. R. W. TAYLOR read a paper on this subject. He stated that cancer of the penis, according to the statistics taken from reliable sources, stands seventh in frequency of all cancers in the male sex and constitutes over five per cent. of all cancers in that sex. It is a disease that belongs to the more advanced years of life and is most commonly met with between the ages of 50 and 60.

**ETIOLOGY.**—Besides predisposition and certain unknown causes, chronic irritation, in the great majority of cases, seems to be the principal causative factor in cancer of the penis. As phimosis is frequently the cause of balanitis and balanoposthitis, that condition takes a prominent place in the etiology of the disease. The disease, however, is not confined to persons who suffer from phimosis; it has been seen in persons with a normal prepuce and

even in some with no prepuce at all. Personal habits have much bearing on the development of cancer of the penis. It will not develop, even in the aged, if the organ is kept clean and dry. It occurs in the majority of instances among men in the lower walks of life and in persons of uncleanly habits. Syphilis is considered by some to be an important etiological factor in the development of cancer of the penis. Dr. Taylor said he did not so regard it. The scars left by syphilis might give rise to chronic irritation and thus produce epithelioma, but this is rarely seen. Five cases have been reported in which cancer followed an injury to the penis. In one of these the injury was caused by the man's wearing two small gold padlocks on his penis. Two of them were due to crushing accidents; in another the prepuce was almost torn off by the bite of a horse, and in another there was an injury to the frenum. In one case reported by Dr. Taylor the patient had a pustule about the size of a pea on the penis; this was picked by the patient by means of a pin and cauterized a number of times; the result was an epitheliomatous nodule. One case is on record in which the disease was said to be due to the fact that the patient had coitus with his wife, who was suffering from cancer of the uterus. Such a mode of origin, Dr. Taylor said, is very doubtful. There are no facts to warrant the assumption that cancer of the penis may, more or less remotely, originate in nervous troubles.

**COURSE AND SYMPTOMS.**—In many cases of epithelioma of the penis the initiatory symptoms are very insignificant and may be long disregarded, especially by those in the lower walks of life. Some may give a history of burning sensations about the date of the onset of the disease. The earlier symptoms usually go unnoticed, as it is more commonly found in patients who have long suffered from recurrent herpes, or balanitis, or balanoposthitis. The disease may appear as a warty growth which develops into a fungating mass. Then, again, the cancerous growth begins in one or more fissures in the mucous layer of the prepuce, or at the very margin, or in the coronal sulcus. Chronic ulcerations of the penis left untreated or badly treated by over-stimulation or cauterization may constitute points of cancerous degeneration. Sometimes these ulcers give rise to warts, which soon degenerate into epithelioma. Whenever a middle-aged or elderly man has a rebellious ulcer of the penis, particularly if there is considerable infiltration and syphilis has been excluded, a fear of cancer may be entertained. The most common mode of origin is in warty growths, which either promptly or after months or years degenerate into epitheliomata. Their liability to undergo malignant degeneration, particularly in men advanced in life, is so great that they should receive prompt treatment. Vegetations of the penis are chiefly found about the coronal sulcus and on the inner layer of the prepuce near the frenum. It is sometimes difficult to say just where benignancy ends and malignancy begins in these growths. In some cases the exuberant development is rapidly accomplished, the growth attaining the size of an orange or apple, or even of a child's head, within a year's time or less. As time goes on the cauliflower appearance of the growth is lost, being changed into irregular fleecy masses. Then, again, we see cases in which the patient presents a little nodule or patch, or a hard, warty growth, like a seed-wart on a boy's hand. There is no pain nor discomfort associated with it, or perhaps a slight pruritus. It gradually grows larger, and months or even years may elapse before it reaches a size sufficiently large to prove annoying. Another and rather rare way for the disease to

make its appearance is in men advanced in years who complain of an inveterate, scaly affection of the glans or prepuce, or both. The symptoms are usually not well marked and there may be only occasional slight heat or itching. There is at first a mild irritative process in the epithelium, with slight thickening and a constant desquamation of small scales. The induration becomes greater and the new growth more or less rapidly develops. Later on fleecy masses are formed like those already referred to.

When epithelioma of the penis is fully developed the symptoms become more pronounced. The lancinating pains are more troublesome; coitus becomes difficult and even impossible. The meatus may be compressed by the malignant growth, thus interfering with micturition, and in some cases causing retention of urine. The urethra may become stenosed by the new growth, but in a short time the urine tunnels its way through it. In the later stages of the disease hemorrhages occur, which are sometimes very severe. One of the most annoying symptoms is the low grade of inflammation, which produces a horridly fetid secretion. Some patients complain of painful erections. The lancinating pains may extend up the penis and into the groins. The health of the patient may remain unimpaired for several years. As time goes on they begin to lose flesh, and present evidences of a deep cachexia. Enlargement of the inguinal glands may not occur in some cases until very late in the course of the disease, while in other cases, where the growth is rapid and exuberant, the general health soon becomes affected and the glands are earlier involved. Curious deformities and distortions of the penis may be produced by the disease.

In the greater number of cases the disease is limited to the prepuce and the glans portion of the penis. The corpora cavernosa, with their firm fibrous sheath, offer a strong barrier to the cancerous invasion, and may remain intact for years. It sometimes develops higher up in the organ, the seeds being carried there by the lymphatics. Extension may also occur by means of the corpus spongiosum.

As a general rule, the glands in the groin are affected on both sides. When thus affected, they become hard, smoothly enlarged, separable from each other, and movable under the skin. In this condition they may remain for months or years. Then exuberant cancerous development may take place in them, and they are transformed into large lobular or oval tumors. Ulceration of the overlying skin then usually occurs, sometimes accompanied by hemorrhages. Or the glands may undergo acute suppuration, followed by malignant degeneration. Metastasis from the secondary cancers in the groin are the exception rather than the rule. Death from cancer of the penis usually occurs in one of two ways: first, and more commonly, by cachexia, and second, as the result of metastasis in the lungs, liver, pleura, etc.

**PROGNOSIS.**—This depends on the time at which the disease is recognized. If the growth is small and favorably situated for removal its ablation may secure future immunity. If it is very large and has existed for several years, the prognosis is less favorable. The condition of the inguinal glands is very important. If they are only slightly enlarged many years may elapse before the fatal result. Cancer of the penis is so sharply limited that the conditions for its removal are more favorable here than in other situations. Still the sad fact stares us in the face that in the vast majority of cases it almost inevitably leads to death. Recurrence of the disease in the stump



left by amputation occurs in about 25 per cent. of cases. It has been stated that amputation of the penis leads to melancholia and suicide. This is very unusual. Generally a man thanks his God that he is rid of the diseased organ.

DR. EUGENE FULLER exhibited a specimen showing cancer of the penis. In that case the growth appeared to have started from the urethra, and as it enlarged it perforated the penis, causing numerous sinuses. Before these sinuses formed the patient had a number of attacks of retention of urine. The penis was very much hypertrophied. Dr. Fuller said he had been unable to get a full history of the case.

DR. J. A. FORDYCE said that in Dr. Fuller's case it was possible that the cancer started in the bladder, and that some of the cancer cells or contagious matter was carried out through the urethra and lodged near the meatus, thus giving rise to this secondary growth. The posterior portion of the urethra did not seem to be affected. The etiology of cancer is a very interesting question, and one that is still very much in doubt. It is well known that chronic irritation of slight intensity is the most potent factor in the production of the disease, but there must be something more than this. Various pathologists have found certain organisms or bodies in cancer cells, which they consider protozoa, and these investigations may lead to a solution of this problem.

DR. B. E. VAUGHAN gave the history of a case of carcinoma of the penis. The patient was a man aged 45 years; married; temperate; no venereal history. His mother had epithelioma of the nose. The patient had always had an unretracted foreskin. This was removed about four years ago, and underneath it was found a small wart. This was removed six months afterwards. It immediately returned and gradually increased in size until July, 1892, when the man entered the New York Cancer Hospital. The greater portion of the glans was involved in the carcinomatous growth and the inguinal glands on both sides were enlarged. Amputation was performed about one inch from the pubes and the enlarged glands in the groin removed. Since that time there has been no recurrence of the growth, and the man has remained in perfect health.

DR. C. A. POWERS referred to the importance of the early recognition of cancer of the penis. The disease is curable, if treated sufficiently early. In the majority of instances, the patients come under observation too late for us to hope to cure them. While the disease usually occurs in elderly men, it does occasionally appear in early life. During the past two years he has seen a number of cases of cancer in persons between the ages of twenty and thirty—not of the penis, however. Two were cases of cancer of the lip, two of the breast, and one of the tongue, the latter in a woman aged twenty-six.

In the early differential diagnosis of cancer the microscopical examination is of much assistance. A sufficiently large segment of the growth, or better still, two or three segments from different portions of the growth, should be removed and submitted to the pathologist. When operation is decided on, Dr. Powers said, the groin should be opened in every case, whether we can make out the enlargement under the skin or not.

DR. F. TILDEN BROWN referred to a case of sarcoma of the penis that had come under his observation. The original lesion developed on the right thigh, about two inches below the trochanter major. This was four years



ago, and in the course of two years or less the right inguinal glands became very much enlarged and from there the process extended to the penis. The organ was symmetrically enlarged and stood erect, presenting the appearance of priapism. The crura were nodular and hard, particularly on the right side. The corpus spongiosum was so nodular that it was almost impossible to pass a catheter. The left inguinal glands were not involved.

DR. W. K. OTIS referred to the importance of an early and thorough operation in these cases. The groin should be opened and the glands removed, whether they are enlarged or not. He spoke of the difficulty of keeping these patients under observation after operation. In one case he saw there had been no recurrence for five years, when the man was lost sight of.

DR. FULLER referred to a case of cancer of the penis which has existed for a number of years. The man has kidney trouble and it was considered inadvisable to operate. There is no glandular enlargement. In spite of the fact that almost the entire glans has been destroyed by the disease the man married recently.

DR. C. W. ALLEN said that while as a general thing he favored an early and thorough operation in these cases, he has seen very good results follow the application of caustic paste. About five years ago he employed this method of treatment in a case of epithelioma of the penis involving the entire under surface and one-half the upper surface of the glans, the ulceration extending into the urethra. The diagnosis of epithelioma was confirmed by the microscope. There was no glandular enlargement; there was no history of syphilis. Pyrogallol was first applied in full strength, and subsequently the caustic paste. The ulceration healed, and the man has remained well since.

DR. SAMUEL ALEXANDER said that while a hard, indurated chancre may sometimes be mistaken for cancer it is much more common to see cancerous lesions that have been pronounced syphilitic. Several such instances have come under his observation. He agreed with Dr. Powers that the groin on both sides should be thoroughly cleaned out. He differed with Dr. Allen as regards the use of caustic paste in the treatment of these cases: the method is painful and certainly has no advantages over the knife.

DR. T. H. MANLEY in speaking of the etiology of the disease and its doubtful infectious nature mentioned the fact that while cancer of the cervix uteri is very common cancer of the penis is exceedingly rare. Heredity seems to be one of the most important etiological factors. As regards the symptoms of the disease, pain, upon which so much stress is laid by the older authors, is not often very severe. In that respect it is very similar to cancer of the cervix. As regards treatment, cancer of the penis is, as a rule, a primary, localized affection. It does not usually spread beyond the lymphatics in the groin. As Dr. Taylor said, it is similar to cutaneous cancer. For this reason the use of caustics in certain cases would be preferable to the knife and just as effective. The applications could be rendered painless by the use of cocaine.

DR. VAN DER POEL referred to the fact that the French authors give phimosis a very important place among the etiological factors of cancer of the penis. One author ascribes it to that cause in forty-two cases out of fifty-nine.

DR. TAYLOR in closing the discussion said he was much interested in Dr. Fuller's case. As the microscopical examination has not yet been made

the case must be regarded *sub judice*. The growth was probably the result of a secondary infection from the bladder. There is no case of primary cancer of the urethra on record.

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## Book Reviews.

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*International Atlas of Rare Skin Diseases.* Editors, P. G. UNNA, Hamburg; MALCOLM MORRIS, London; H. LELOIR, Lille, and L. A. DUHRING, Philadelphia. Parts VII., VIII. and IX. Leopold Voss, Hamburg und Leipzig.

The high standard of artistic excellence which distinguished the plates of the first numbers of this atlas has been fully maintained in the succeeding numbers.

Plate XX. *Farcin chronique térébrant*, by Ernest Besnier, gives a most admirable representation of the skin lesions of the chronic form of farcy or equinia occurring upon the face. The disease in this location possesses a special clinical interest from its resemblance to the lesions of lupus and syphilis. As the author suggests, in the differentiation of serpiginous, ulcerative, mutilating lesions of the face, we must consider not only syphilis, lupus and epithelioma, but also farcy. The pertinence of this suggestion is rendered apparent from an examination of this plate, as the similitude of the lesions to those of syphilis is most striking; but the clinical history of the case, the penetrative character and mode of evolution of the lesions, and the presence of cicatrices of farcy "buds" on the skin, permitted the diagnosis of chronic glanders, which was confirmed by the post-mortem examination and the successful inoculation of an ass and a guinea pig with the bacilli.

Plate XXI. *Cornua Cutanea Syphilitica*, by G. Lewin and J. Heller, represents cutaneous horns occupying the palms of both hands of a syphilitic subject and rising to a height of from one-half to nearly two centimeters. The special interest of this case is due to the demonstration to the author's satisfaction, at least, of syphilis as the etiological factor.

Plate XXII. *Keratosis Follicularis Contagiosa*, by H. G. Brooke, gives a most faithful representation of the disease first described under the title of Keratosis Follicularis, by Dr. P. A. Morrow in this Journal (1886). Dr. Brooke prefers the title proposed by Dr. Morrow, as it "expresses the peculiar pathological process with much greater accuracy than those involving comparisons with other forms of disease." He adds the qualifying adjective *contagiosa*, as in this case the contagious nature of the disease was inferred from its occurrence in more than one member of the family, with no history of heredity.

Plates XXIII. and XXIV. *Psorosperose folliculaire végétante*, by J. Darier, and Plate XXV., *Zwei Fälle von Darierscher Dermatoze*, by E. Schweninger and F. Buzzi. Plate XXIII. portrays the clinical appearances of the first two cases ever described under this title. Plate XXIV. shows the histological appearances of numerous sections taken from these cases. Plate XXV. illustrates the clinical features of the same disease in two cases observed in Germany. Notwithstanding the exhaustive study of this com-

paratively rare disease by various investigators, little light has been thrown upon its nature and etiology. A very complete résumé of our knowledge of psorospermiosis was presented by Lustgarten in the January number of this Journal for 1891.

Plate XXVI. *Sur une forme particulière de pemphigus malin*. Plate XXVII. *Forme non commune de Kératodermie*, "Porokeratosis," by Vittorio Mibelli, and *Psoriasis Conjunctivæ Palpebrarum (Psoriasis Ophthalmica)*, by Arnold Sack, and Plate XXVIII., *Akrokeratoma Hystriciforme Hereditarium*, are all admirable portrayals of skin diseases, which are remarkable no less for their rarity than for their curious clinical features. P. A. M.

*Surgical Disorders of the Urinary Organs*. By REGINALD HARRISON, F.R.C.S. Fourth Edition. London: J. & A. Churchill, 1893.

This edition is made up of the third, largely rewritten, together with the substance of the author's Lettsomian lectures (1888) and his lectures before the Royal College of Surgeons (1891), accompanied by numerous new illustrations.

The subject matter of the book, although divided into thirty-six lectures—nine less than the previous edition—remains undiminished. In the present work a few of the old lectures, as, for example, the one on examination of the urine, have been omitted, while others, the subject becoming less important, have been much abridged and incorporated as sections in new chapters. The question of divulsion has been treated in this manner. Among the subjects treated very fully, simple mention of which were made formally, is that of the Bilharzia Hæmatobia, under the heading of Endemic Hæmaturia. Illustrations of this parasite are given. The lecture on Toxic Urine remains substantially as in the former edition, the author making but slight allusion to the recent bacteriological literature on the subject, his opinion evidently being reserved. With regard to rupture of the urethra Mr. Harrison is of the opinion that prompt perineal section and drainage is all that is necessary, and that the ruptured ends of the urethra, under these conditions, will gradually approximate themselves without the aid of sutures. Many kind words are spoken for the lateral operation for stone. This is interesting in view of the fact that a number of recent writers are inclined altogether to discard this operation.

With reference to suprapubic cystotomy the author advocates open drainage with Guyon-Pessier tubes, and, contrary to the Necker school, does not try, by vesical suture, for union by first intention. The Petersen bag is not thought necessary in performing this operation. Favorable mention is made of the transverse incision and of Albarran's article on the subject, though the author states that personally he has had no experience with this procedure. The subject of prostatectomy is carefully considered. In speaking of extroversion of the bladder and of the lack of success following the many operations devised for the relief of this distressing condition, the author is disposed to think that eventually the procedure to be adopted will be to establish a renal fistula in connection with one kidney and then to perform nephrectomy in connection with the other.

Before attempting to repair any penile deformity involving the urethra by means of a plastic operation, the author insists on perineal section and drainage as a preliminary step in order to insure success.

The surgery of the kidney and ureter is barely mentioned, but one short

lecture being devoted to the subject. At the opening of this lecture Mr. Harrison states: "The surgery of the kidney has recently made such rapid strides that it would not be possible to include within the scope of these lectures any systematic description of those disorders which come within its province, or where the surgeon has to supplement the work of the physician. I shall, therefore, not attempt to do more than offer a few remarks on certain points which have interested me in connection with this subject."

Taken as a whole, the work is very interesting and instructive, especially in particulars which it is not usual for books devoted to this subject to dwell upon. E. F.

*Monographie de la Goutte Saturnine.* (Monograph on Gout due to Lead Poisoning.) Par FRANK GALLARD, Paris, L. Battaille et Cie, 1893.

In this work the author reviews the literature most thoroughly and incorporates his own opinions as well as those of numerous other authorities. Seventy-five cases are cited in the way of illustration. The following points are of importance in distinguishing this form of gout from the usual variety. In the former instances the patient is usually an artisan; as, for instance, a painter or plumber, young, or at most, middle aged, with no family history of gout, and anæmic rather than plethoric. In many of these cases, also, there are associated other symptoms of lead poisoning. During an acute attack the joint is not red and inflamed, there is no increase in the uric acid in the urine as occurs in true gout. In fact, if the urine is carefully examined in these lead cases the amount of uric acid as well as urea will be found to be diminished below normal, and associated with this diminution it is usual to find albumen. Urate of soda deposits in connection with the joints involved are customary in both varieties of the disease. The prognosis in lead gout is bad, the attacks becoming more severe and lasting. As the gout progresses general symptoms, also dependant on anæmic and kidney insufficiency, manifest themselves. Death is generally due to uræmia.

The kidney, in these cases, has the general appearance common to chronic interstitial nephritis. On microscopical investigation, however, conditions peculiar to this disease are observed chiefly confined to the medullary tissue in connection with the straight tubes and the loops of Henle, but extending into the cortical tissues along the convoluted tubes. In the medullary portion there is a peculiar striated appearance which, on close observation, is found to be due to crystals of urate of soda deposited in connection with the uriniferous tubes destroying the secreting epithelium and eventually setting up sclerotic changes, which finally become general. In ordinary interstitial nephritis the sclerotic changes seem to commence in connection with the arterioles and are consequently chiefly confined to the cortical tissue. The general results, however, of these two pathological processes are the same. The liver is liable to be found sclerosed, the large arteries atheromatous and the heart hypertrophied. The blood is lacking in red corpuscles and overcharged with uric and phosphoric acids. Gallard finds that this form of lead poisoning is more common in England among workers in lead than those on the Continent, and is disposed to think that the heavy beers and abundant meat diet of the English are predisposing factors. The objects of treatment in this affection should be in the earlier



stages to endeavor to eliminate the lead and in the later stages combat the anæmia and the kidney insufficiency. To eliminate the lead hot baths, massage and the administration of bromide and iodide of potassium are advocated.

This subject has, apparently, received little attention in this country. A knowledge of Dr. Gallard's monograph would doubtless prove of value in many instances. E. F.

*De la Fréquence des Maladies Vénériennes et des Moyens de la Faire Diminuer.* (The frequency of Venereal Diseases and the means of Diminishing it.) DR. ARMAND LAURENT. J. B. Baillière et Fils, Paris, 1893.

This little volume deals, of course, with the social evil, the specialty of French hygienists and economists ever since the time when prostitution was considered as such. The dissemination of venereal maladies in the region occupied by the Third Army Corps is the subject of the first division of the work, accompanied by illustrative diagrams; then follow the consequences of this frequency as regards the individual, the family and society: next the causes of the wide spreading of the diseases in the region referred to. His means for amelioration of the condition are: (1) Diminution of the number of inns and taverns and other places where clandestine prostitution may be carried on, (2) interdiction of prostitution to minors, (3) immediate enactment of a law to confer full powers on the prefect of each department to carry out prophylactic measures against the propagation of the venereal disease. The report of the commission on this subject in the Department of Seine-Inférieure occupies the last pages. J. C. J.

*Chirurgie des Voies Urinaires. Études Cliniques.* (Surgery of the Urinary Passages. Clinical Studies.) E. LOUMEAU. Feret et Fils, Bordeaux, 1894.

The volume is, as its secondary title indicates, a compilation of facts gathered from clinical experiences without any particular method of arrangement other than that brought about by their chronological order. The cases selected are all of practical interest, and include pathological conditions of the kidney, bladder and urethra. They are related with great fidelity to detail and with little concern so far as the author is interested in regard to their outcome. They are commonly followed by critical comments suggested by each particular case. The book is now in its second edition; it has been enlarged and embellished by five plates in black and colors. The majority of the papers have been published previously in the *Journal de Médecine et Annales de la Polyclinique de Bordeaux*.

In spite of the confusion entailed by the lack of regular order which would naturally prevent any use of it as a text-book, it may serve very well as a reference. Each chapter has its heading in a concise form, and in the table of contents a summary of each chapter will be found. The book contains many hints profitable alike to the surgeon and the patient. As an example of the arrangement pursued, the first chapter will serve admirably. It is devoted to two cases, one of perinephritic abscess opening into the bronchi, the second of urethral fistula, consecutive to ligature of the penis. The history is given in each, the status at the time of operation, the concurrent accidents, the method of operation and the final result.

The volume is well gotten up, printed in large type on thick paper, the pages with wide margins and the few plates good. It seems altogether worthy of a much more durable binding than the paper in which it appears.

J. C. J.

## Selections.

### THERAPEUTIC NOTES.

**Thyroid Extract.**—DR. P. ABRAHAM recently reported to the London Medical Society the results of the administration of this remedy in 65 cases of psoriasis, 7 of eczema, 5 of lichen planus, 5 of lupus, 2 of chronic urticaria, and one each of prurigo senilis and adenoma sebaceum. Of the cases of psoriasis, 17 were thrown out, some improvement was noted in 18 (only 7 were under thyroid treatment alone), the result was negative in 16, while in 15 the eruption increased during the use of the drug. Three cases of lichen planus were markedly improved, and the same number of eczemas were benefited. Neither case of urticaria showed any amelioration. He claims two lupus cases exhibited improvement. His general conclusions are that the ingestion of the thyroid glands has no constant effect in psoriasis and other cutaneous diseases, that it often produces marked constitutional disturbances, and that in a large number of cases the results were negative. In a few the trouble was aggravated, although in a certain number a distinctly curative effect was noticed.

It has been suggested that from its action on the horny layers of the skin, thyroid extract might prove of considerable service in ichthyosis and xeroderma.

**Skin Grafting in Lupus.**—While this can hardly be classed under therapeutics, it is, nevertheless, in the line of treatment, and may find a place here.

Lang presented to the Vienna Society of Dermatology a young man on whom he had operated for lupus of the face. The lupous tissue was excised through its whole extent, and the surface almost entirely covered by grafts taken from the thigh. A few days later the parts covered were completely healed, although the grafts were placed on a level some millimetres below the surrounding skin. There was no return in the case and, according to Lang, there need be none, if the incision is carried deeply enough.

**Static Electricity in Scleroderma.**—After a faithful trial of arsenic without appreciable results, Du Rocher by the local use of the static form of electricity, obtained from a modified Leyden jar apparatus, secured the complete disappearance of a plaque of scleroderma covering one-half the dorsal surface of the foot. The discharge is made at the point desired in the form of a shower of little sparks over a limited surface, thus preventing the production of pain or discomfort. He believes that this method of administration will prove serviceable in other cutaneous diseases, such as eczema. (*Journ. des Mal. Cut. et Syphil.*)

**Chrysarobin in Alopecia Areata.**—In alopecia diffused over the entire scalp, Leistikow obtained from the use of this drug the following results:

in 65 per cent., no change ; in 15 per cent., appearance of downy hair ; in 9 per cent., zones of strong, healthy hair ; in 11 per cent., cure with 5 per cent. of relapses. In the circumscribed form, 4 per cent. showed no improvement ; 3 per cent., no result, but no progress of the disease ; in 35 per cent., the lanugo appeared, and 58 per cent. were cured with 30 per cent. of relapse. These percentages of cure are higher than are usually obtained, so that it seems due the author to give his formula for application.

R. Chrysarobin.....	30 gr.
Colophene.....	5 gr.
Ceræ flav.....	35 gr.
Ol. olivar.....	30 gr.

The amount of chrysarobin is, of course, varied to suit different patients. (*Monatsh. f. Prakt. Derm.*)

JOHNSTON.

**After Treatment of Epicystotomy.**—D. BORELIUS (*Hygiea*, No. 8, 1893). The writer at the recent Congress of Scandinavian Surgeons read a short paper on three cases, where he had sutured the bladder wound after suprapubic cystotomy. The wound healed in a short time. After death of these patients from other causes, he examined the cicatrix from the interior of the viscus, and found that only the skin had healed. At the place where the sutures were applied to the bladder he found a small cavity filled with detritus and of the size of a walnut. Its walls were irregular, and reminded one of a *vessie à colonne*. Hence, he warns against too much confidence in apparently complete healing after suturing of the bladder in suprapubic cystotomy.

F. H. PRITCHARD.

**The Linea Fusca in Children.**—DR. ADSESEN of Copenhagen, (*Howitz's Gynækologiske Meddelelser*, Bd. 10, H., 1-2). The writer has examined two hundred children with regard to the existence of the pigmented abdominal line reaching up from the pubes towards the navel, and which is regarded as characteristic of the first pregnancy. Of these one hundred and five were girls, ninety-five boys, of fourteen days to thirteen and a half years. Out of these children one hundred and twenty-eight had the characteristic linea fusca or pigmented median abdominal line of pregnancy. Of these seventy-six were girls and fifty-two boys. Its frequency increased with age. In half of them the color was quite pronounced, and in the others only indistinct. Brunettes seem more predisposed than blondes, though not especially. In eight of the children the line reached above the umbilicus and, in some, even up to the ensiform cartilage. Deviations to the right or left of the median line, as Professor Schoenberg has described in adults, were observed in several.

From this he concluded that this line of pigmentation is not to be included in the characteristic signs of pregnancy, as besides being found in children, it may be observed in diseases of the genital tract as, for example, in uterine myomata.

F. H. PRITCHARD.

**Suprapubic Cystotomy in Impermeable Urethral Stricture.**—DR. LINDFORS (*Hygiea*, No. 8, 1893). The author read a paper on this subject before the recent Congress of Scandinavian Surgeons, in which he gave the details of two cases. Catheterization was impossible, and urgent indications

forced him to make a vesical fistula. The first case was that of an elderly man with prostatic hypertrophy and ankylosis of the hip-joint, where a suprapubic fistula was done with very good functional results. He improved so much that he was discharged. He died later of senile marasmus. The second case was a younger man with an inflammatory stricture and various symptoms which indicated operative measures. He then presented the indications for operation for vesical stricture. He, like Guyon, is not in favor of modern prostatectomy, as is so often done by American surgeons. In the discussion Dr. Rovsing reported a case of inflammatory stricture of fifteen years duration, where resection of the urethra was done with very good functional results.

F. H. PRITCHARD.

**Precocious Syphilitic Albuminuria.** PAUL GASTON. (*Annales de Derm. et Syphil.* December, 1893.)

There are two points of interest in the history of patient, (1) a chancre of the abdomen, probably the result of contagion by means of bed coverings through the scratch-marks of pediculosis, (2) the occurrence of an albuminuria from a nephritis demonstrated by the presence of albumen and granular casts, simultaneously with the outbreak of the roseola. The nephritis was not due to cold, to intercurrent disease nor to the ingestion of mercury; its concurrence with the chancre, roseola and œdema proves its origin. Under the influence of a milk diet and a daily dose of three grammes of potassium iodide, the œdema disappeared and the quantity of albumen fell from 1.37 gr. to 30 centigr. per litre.

JOHNSTON.

**Congenital Syphilis of Paternal Infection.** K. BERGH, of Copenhagen (*Hospitals Tidende*, No. 26, 1893.)

The author records a case of congenital syphilis of paternal origin where the mother escaped infection. A primipara was delivered of a female child at full term. Normal puerperium. Neither the mother nor any other woman nursed it. Five weeks after, the child was brought to the hospital, with distinct signs of congenital syphilis. The child's nurse had already observed, in the third week, that it had discharge from the nose, moist patches around the anus and an eruption on its body. Fully six months after that the mother entered, with recent syphilis, excoriated indurations on the labia minora, enlargement of the inguinal glands, later of the cervical and of one submaxillary gland, redness of the pharynx, headache and other syphilitic prodromata. No eruption appeared even after nine weeks treatment by inunction. About nine months after her discharge she returned with a recurrence.

F. H. PRITCHARD.



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### OSTEOSIS OF THE SKIN OF THE FOOT.<sup>1</sup>

BY

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IN March, 1892, Dr. Sherwell presented a case at the New York Dermatological Society for diagnosis.<sup>2</sup> A girl, æt. 6, born in Brooklyn, of American parents, had a lesion in the sole of the left foot, which the mother had first noticed about two and a half years previously. It was a thickening of the skin and subcutaneous tissue, occupying about one-third of the plantar surface of the foot, chiefly under the calcis, and a little to the outer side. A year and a half after the lesion in the sole appeared the fourth toe became involved and gradually increased in size. The skin of the entire toe takes part in the process, though the lesion is most marked in the distal phalanx. The enlargement is symmetrical, and the diameter of the toe is 1 cm.

It is stated that there has been little increase in the amount of skin involved from the time the lesion was first noticed until the operation in December, 1892—a period of three years. Though from the subsequent history and from the gradual increase in the size of the toe I am inclined to think it was from lack of observation on the part of the mother. Certain changes, however, have taken place; the skin has grown harder and nodosities and irregular thickenings have appeared on its surface. The skin of the toe has also become indurated.

<sup>1</sup>A report from the Pathological Society, March 14, 1894.

<sup>2</sup>JOURN. OF CUTAN. AND GEN. URIN. DIS., March, 1892, p. 119.

At the time, Dr. Sherwell described the condition as follows : "The lesion now consists of a plaque of cartilaginous hardness, studded here and there with tubercular nodosities, about six in number, the whole occupying about one-third of the external plantar surface of the left foot.

"The skin and subcutaneous cellular tissue are all involved in the process, still the plaque can be moved relatively freely over the subjacent tissue. The epithelial tissues, while somewhat thick and horny, present no other unusual features. There are few subjective symptoms while the foot is at rest, but on account of the hardness it is difficult to walk upon it, seeming to act as a foreign body without the irritation the latter would cause. The little patient always walks on the ball of that foot.

"The lesion on the fourth toe is of the same relatively painless character, and is curiously clubbed on top, and the peculiar cartilage-like feel is also present. On no other part of the limbs or the body is anything that is abnormal. The child is of healthy parents as far as can be ascertained, and is a healthy child.

"I cannot class the trouble as scleroderma or carcinoma *en cuirasse*, and present her for diagnosis."

An operation was performed in December, 1892, when the plaque and the fourth toe were removed. It was noticed in cutting out the plaque that the knife met with more resistance beneath it than normal subcutaneous tissue would have offered even in the sole of the foot.

The toe and the plaque were put into alcohol, and have been well hardened. The plaque now measures 1 cm. through its thickest portion.

On the night of June 7, 1893, Dr. Sherwell kindly looked up the case with me, and it was found that the growth has recurred and is advancing. The scar is adherent to the bone, and in front of the scar the skin and subcutaneous tissue are infiltrated with a substance which from its hardness and resilience seems to be cartilage. It is of new formation, having appeared since the time of the operation.

In May last Dr. Piffard brought a portion of the growth which he had decalcified in a 2 per cent. mixture of nitric acid and 95 per cent. alcohol to the Loomis Laboratory, and asked to have sections made for him. The sections, as the microscopic report will show in detail, contain cancellous bone. He suggested the term *osteosis*, as the lesion is a general infiltration of the skin with bone rather than a distinct tumor formation.

The body of the plaque, its advancing edge, and the toe have been examined. The latter was cut at two different levels—through the articular cartilage, and through the body of the phalanx—with the view of determining, if possible, the origin of the process.

All the pieces were decalcified in the above mixture, and it



FIG. 1.

SHOWING EPIDERMIS AND DISTRIBUTION OF BONY SPICULES BELOW IT.

Zeiss—35 mm. Ocular,  $1\frac{1}{4}$  in.

is found that the acid has interfered to a certain extent with the staining properties of the cells.

The statements made in the following report have been drawn from a study of twenty different sections.

*Microscopic Examination. Sections through the Body of the Plaque.*—The sections contain cancellous bone which runs close up to the epidermis. The spicules vary in size and shape,

and are irregularly distributed throughout the tissues. Many of them connect with others. The interspaces are filled chiefly with fat-cells, blood-vessels, and a loosely woven connective tissue. Small nerves may be seen scattered here and there. Sweat-glands of normal appearance lie in the deeper parts of the sections. Their ducts lead up between the spicules of bone, and pass through the epidermis in the usual corkscrew-like passages. The spicules are most abundant in the sections from this part of the growth, which would account in part for its greater hardness, but they are smaller. The variations in the size and the irregularity in the shape of the spicules appear to result chiefly from absorption. Some of the spicules have irregular openings in them from a similar cause. Frequently distinct rows of cells may be seen along the sides of the spicules, but as a rule they do not lie under a definite membrane. Large multinucleated cells are sometimes associated with them, especially where the spicules are thinnest. Mingled with the fat-cells generally in the interspaces there is a tissue of marrow-like structure. It consists of numerous unincleated cells, a little larger than lymph-cells, the nucleus occupying nearly all the protoplasm. The large multinucleated cells, above mentioned, occur with these, and fine connective tissue fibres run among them all in different directions. The spicules of bone vary in structure. Some consist merely of a homogeneous ground-substance with rounded or flattened cells scattered through it; in others the cells are branched and arranged in irregular rows or are disposed in concentric rows around a central opening. No distinct fibrillation could be made out in any of them. As a rule, the spicules are composed of irregular lamellæ, between which are branching lacunæ filled with bone corpuscles. Small blood-vessels are included in the larger masses of bone, and in rare instances the lamellæ are arranged concentrically around them, but there is a lack of regularity, characteristic of the Haversian system, in the disposition of the bone corpuscles.

The connective tissue immediately under the epidermis is very dense, in fact is almost tendinous in structure.

*Edge of Plaque.*—This portion of the specimen is not so thick, and contains less bone than the part just described. It contains also masses of cartilage. Some of the cartilage cells are branched as in foetal cartilage. Though the features presented by these sections are for the most part such as have been described, other points of interest may be noticed. There is reason to believe that a transformation of fibrous tissue into



cartilage is taking place. Cells immediately adjacent to cartilaginous masses may be seen to increase greatly in number, to arrange themselves between bundles of dense fibrous tissue, and to become flattened out. They are of the same size, shape, and appearance as the outermost cells of the cartilage, and merge imperceptibly into them. These cells correspond very



FIG. 2.

SHOWING THE ATTEMPTED FORMATION OF HAVERSIAN SYSTEMS, AND THE BONE CORPUSCLES.

*Spencer*—1 in. Ocular,  $1\frac{1}{4}$  in.

closely with cells in a like situation in an ossifying tibia from a six months' foetus. There is an entire absence of rows of osteoblasts around these centers. Most of the cartilage masses seem to be extending in this manner. This transformation was suggested in certain sections from the older part of the growth, but in them, as a rule, the ossification of cartilage already

formed was the most prominent feature. The method by which the cartilage extends would explain the absence of a periosteal layer. But without a periosteum it is not so clear why the osteoblasts arrange themselves in definite rows along the sides of the calcareous cartilages.

*The Ossification.*—In all essential details ossification is proceeding regularly. I shall consider it in the three stages described by Schäfer. Many of the spicules have ossified only



FIG. 3.

SPICULE MORE HIGHLY MAGNIFIED. A ROW OF OSTEOBLASTS INDISTINCTLY SEEN ALONG THE UPPER BORDER.

*Spencer*— $\frac{1}{2}$  in.

*Zeiss*—Projection ocular, 4.

so far as the deposition of calcareous granules in the cartilaginous matrix, without any noticeable change in the appearance of the cells. As ossification proceeds the cells swell up, but do not as a rule arrange themselves in any characteristic manner. Rows of osteoblasts develop along the sides of the cartilaginous masses with or without the occurrence of the large multinucleated cells or osteoclasts. Then the irruption commences. The

irregular openings found in many of the spicules may be explained in this way, for they contain both kinds of cells. Ranvier doubts whether osteoclasts are much concerned in absorption, but be this as it may, it is undoubtedly true of this specimen that where these large cells are most numerous the spicules present the greatest irregularity in shape, and are thinnest. Their presence in certain of the spicules would also suggest this function, having burrowed there from the side. Only in exceptional instances do the osteoblasts lie under a definite membrane. They may be seen at times to become included between fibrous layers to form bone corpuscles. Where ossification is complete, both osteoblasts and osteoclasts have disappeared and the bone has an irregularly lamellar or concentric arrangement. The lacunæ are branched and filled with bone cells.

There are several areas in which typical ossification occurs, with marked swelling of the cells, their arrangement in definite rows, irregular absorption of the cartilaginous matrix, and the entrance of blood-vessels into the spaces thus formed.

*THE TOE—Sections through the Body of the Phalanx.*—There is a notable absence of new bone in the dermis and subdermic tissues. An excessive development of very dense, almost tendinous fibrous tissue is the principal cause of increase in the diameter of the toe. All the normal elements of the skin are present. The central canal of the bone contains spicules of irregular shape and arrangement, with fat cells and blood-vessels filling the interspaces. The number of bone corpuscles is noticeably small, and there are no osteoblasts along the sides of the spicules. In the cartilaginous ring which surrounds these, and to which they are attached, ossification proceeds regularly. But there is no periosteum even here, and at irregular intervals around its periphery the transformation of fibrous tissue into cartilage, with a consequent extension of the ring, is more evident than in sections from the edge of the plaque. Where the cells are distinctly cartilage cells, and even where they have begun to swell and arrange themselves in a definite manner for ossification to take place, fibrous bands may be seen running among them. Instead, however, of the cells arranging themselves in rows at right angles to the advancing line of ossification, they become grouped, apparently from repeated subdivision—the number of cells in each group being a multiple of two. At this point absorption begins with the subsequent building up of the spicules that are left. The cells in the outer part of the cartilage, where it is extending, are flattened, and



some of them are slightly branched. At one point in the ring cartilage is absent, its place being taken by fibrous tissue not yet transformed.

Concerning the sections through the *articular cartilage* there is little to be added. However, it is worthy of note that a true epidermic formation, consisting of all the layers quite perfectly developed, runs in crescentic form one-fourth the way around the bone, and almost immediately adjacent to it. I examined a number of sections and the block from which they were cut to make sure that this did not result from an accidental infolding of the skin. Its presence in this situation I am entirely unable to interpret.

The order of development in the lesion would appear to be the following: primarily a hyperplastic formation of very dense fibrous tissue, its transformation into cartilage, the extension of the cartilage thus formed by a further transformation of the adjacent fibrous tissue and the subsequent ossification of the cartilage. This transformation of fibrous tissue into cartilage cannot be regarded as a pure metaplasia because of the marked cell-proliferation accompanying it.

There is no evidence in sections of the plaque to warrant the belief that the lesion took origin from the periosteum or pre-existing cartilage, and that furnished by sections of the toe may be disregarded. The chief change in the toe, the principal cause of its increase in size, is an excessive development of fibrous tissue. Moreover, this fibrous tissue is most abundant immediately under the epidermis, and not around the cartilaginous ring of the phalanx. The extension of this ring seems to be simply a part of the general process, and not the starting point of it. Furthermore, if the process had begun by an extension of the pre-existing cartilage, it is reasonable to suppose that the plaque would have been attached to the underlying bones. But such was not the case. It could be "moved relatively freely over the subjacent tissue." While it is true that bone is present throughout the entire depth of the sections ossification has been completed chiefly in the parts just beneath the epidermis. And as it is probable that ossification began in the cartilage first formed, I must think that the transformation first occurred in the dermis itself or immediately below it.

Metaplasias, both physiologic and pathologic, are of common occurrence. Ziegler says, "That of the several tissues belonging to the connective tissue group, one may pass into another by sim-



ple modifications, partly affecting the cellular elements, partly the ground-substance." But these metaplasias "are confined to the connective tissues—fibrous tissue, cartilage, bone, mucous, tissue and adipose tissue, are, so to speak potentially convertible." As instances of the transformation of fibrous tissue into cartilage I may cite the sesamoid fibro-cartilages which form in tendons, and the connective tissue tumors in which cartilage develops. Arterial sclerosis sometimes results in the formation of cartilaginous patches in the walls of the vessels. In the disease called *myositis ossificans* we have an instance of the transformation of fibrous tissue into bone, for muscle is not capable of undergoing this metaplasia. It takes place in the inter- and intra-muscular septa.

The proneness of hyaline cartilage to ossify is too well known to need more than mention. Ziegler goes so far as to say that it is "at best a transitory structure in man."

The most rational explanation of the etiology in this case seems to be that it is due to a congenital predisposition to hyperplasia and metaplasia of the connective tissue in the dermic and sub-dermic structures. Syphilis may be excluded, and it cannot be ascribed to any special irritation resulting in an inflammatory condition. The lesion, as the history shows, is notably free from any signs of inflammation. It is true that the child goes barefoot in warm weather, but if this alone were the cause we should expect to find a similar development in the other foot, and also that the lesion would be of commoner occurrence.

When bones develop in abnormal situations in the body they are usually the result of long-continued irritation leading to inflammation. The American Text-book of Surgery states, however, that "a few cases have been observed of an early-commencing, slowly-advancing, general muscle inflammation, starting usually in the neck and back, in which after a time the atrophied parts become the seat of bone formation, myositis ossificans, the cause of which is as yet undetermined."

In riders' or exercise bones, we have an example of bone formation, the result of long-continued pressure, though the ossification may be of syphilitic origin at times. Hod-carriers also are known to develop new bony formations under the skin of the shoulder where the weight of the hod falls.

Bone may form under the conjunctiva or in the corpus vitreum as a result of inflammation.

The so-called bones of the pleura and dura mater, according

to Foster's Dictionary, are densely fibrous structures which have become calcified.

Herniæ sometimes develop a cartilaginous or bony sac.

In conclusion I wish to express my thanks to Dr. Sherwell for permitting me to make use of the case.<sup>1</sup>

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AN UNUSUAL AND EXAGGERATED CASE OF IMPETIGO CONTAGIOSA BULLOSA.

BY

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THE subject of pure bullous diseases is not only an interesting one, but also of more than ordinary importance, owing to the prognosis which they entail and the treatment which they demand. In reporting, therefore, a case of a form of such eruptions, banale and benign in itself, there is the intention of directing attention to the fact that the presence of bullæ alone on the skin does not constitute always a pemphigus, but it may indicate diseases which, properly estimated, are of no consequence to the individual or to the somatic health, but yet, when erroneously conceived, may become of grave moment through the development of secondary and subsequent processes and conditions. At the same time, the case is so exaggerated an example of its kind that it is for that reason alone worthy of record.

Peter, male, age 8 years, was seen by me in the service of Dr. Walter James in Bellevue Hospital, February 11, 1891, and I have to thank him for kindly turning the case over to me for study and observation. The history of the patient prior to his admission to the hospital was indefinite and unsatisfactory, and details in regard to the mode of development of the process, the locality primarily implicated by it, and its subsequent course were all unobtainable. It was only possible to discover that he had been vaccinated about one month previously, and that the eruption began eight to ten days later. The boy was living at the time under poor hygienic conditions, was badly fed and cared for, and when seen he was anæmic,

<sup>1</sup> The photomicrographs used in illustration have been kindly taken for me by Dr. Fordyce.

thin and poorly nourished. His functional health when he entered the hospital was fairly good, and continued so during the time he was under care. The urine was examined and contained neither albumen nor any abnormal constituent. He had no elevation of temperature during the entire course of the disease, except for a short time, as will be mentioned later. When he was examined, the site of the vaccination was seen on the left upper arm still unhealed, fungoid in appearance and bathed in a sero-purulent fluid. Over the body, an eruption was distributed which, though consisting of lesions of various size, conformation and character, yet all bore the impress of an evolutive origin from a single primary lesion—a bulla. On the scalp there were only discrete, thin crusts, more or less circular in shape, of various sizes, light yellow to brownish in color, and only slightly adherent to the reddened, or moist base upon which they rested.

On the face, similar crusts were found and also bullæ, which were single and tense, with clear contents, and without any surrounding zone of redness. (Fig. 1.) They occurred on the forehead and cheeks, but were aggregated especially around the mouth. In the conchæ of the ears were large bullæ similar in character, but on the lobes there were raw, moist areas surrounded by bullous borders.

The entire front of the neck was occupied by the eruption. It was denuded of epidermis and moist in great part, but also covered in portions with crusts, while in others it was dry, red and scaly. The border of this area was polycyclic and serpiginous in outline—evidently the result of the confluence of separate and discrete lesions during their peripheral extension—and it was composed of crusts, bullæ the size of peas and flaccid bullous elevations due to the undermining of the epidermis by fluid. On the back of the neck, a similar, though smaller patch existed.

The lesions on the trunk were situated especially over the right scapula, on the flanks and the lower back, and they were constituted by raw-looking moist areas, the size of a silver dollar, encircled by a continuous bullous wall about a quarter of an inch broad; or the periphery was composed of separate bullæ, the size of a large pea, and of crusts. The bullous ring around some of the areas was continuous and uniform, but around others it was broken and the periphery was composed of discrete bullæ, crusts and narrow bullous elevations of varying lengths. There were also other lesions, consisting of a small



FIG. 1.



crusted area in the center, surrounded by a bullous ring one-third to nearly one inch in breadth. (Fig. 2.)

On the buttocks, the lesions were numerous and quite closely aggregated and similar to those already described. The process extended from here to the perineum, the penis, scrotum and inguinal regions. The areas of contact were inflamed, bright red, moist, and bounded by polycyclic contours composed of crusts and bullæ. The upper and lower extremities were both severely affected. On the left upper arm, its posterior surface from the shoulder to the elbow was occupied by several large lesions. They were raw and moist, or crusted in their centers, and bounded in portions by a continuous bullous wall, in others by discrete bullæ, or by flaccid undermined epidermis, or by crusts. On the anterior surface of the forearm, just below the elbow, there was another lesion similar to those already described and also one immediately above the wrist. On the right arm, the lesions were localized especially about the elbow, and presented substantially the same appearances. Both hands on their dorsal surfaces were occupied by bullæ of various sizes, but the palms were diffusely affected. In portions there was crusting in others raw moist areas, and here and there a distinct bulla,



FIG. 2.

but over the majority of their superficies the epidermis was undermined and lifted up by a slight amount of fluid, and a flaccid, wrinkled, bullous formation was the result. The periphery of this area, which trenched laterally upon the dorsum of the hand and above on the wrist, was, as in the other lesions on the neck and arms, composed of bullous elevations and of crusts, but it was ill-defined at the interdigital spaces, into which the process had extended and uprooted the epidermic covering. The affected areas were in these spaces raw and moist and bounded by ragged epidermic remnants and débris. The nails themselves were not implicated, though bullæ had arisen around the base of some of them.

The thighs presented only a few lesions, and these were located on their posterior aspects especially. They were one to two inches in diameter, and consisted of a central crust, or of a red, moist, or dry, scaly area, surrounded by a broad bullous periphery, or by a single, double or even triple row of pea-sized bullæ. On the legs and feet marked implication of the skin was noted.<sup>1</sup> Just below the knees anteriorly, large lesions were present, which were composed of a central bulla, as large as a filbert, surrounded by one or more rings of pea-sized bullæ. On the posterior surfaces, more or less confluence of the lesions had taken place and irregularly-shaped, crusting, denuded and moist areas, bounded by a bullous and crusting periphery, had formed. They were continuous with the patch which covered the ankles and the entire plantar surfaces of the feet. On these latter, the appearances were precisely those which were mentioned as present on the palms of the hands.

The affected areas here also extended over on the dorsum of the feet and between the toes, but there were, in addition, separate distinct bullæ and bullous rings distributed here and there over the former surfaces.

The patient was under observation and treatment until the middle of April, when he was discharged from the hospital entirely free from any eruption, and in a far better condition of general health than when he entered. During his stay he had been carefully watched by myself and by Dr. M. Echeverria of the house staff. All changes which took place had been noted by both of us. The boy's functional health was looked after, and his appetite being good, he gained in weight and strength steadily. He suffered only from some itching, and

<sup>1</sup> Unfortunately, being out of focus in the photograph, only the lesions on the posterior aspects of the legs are seen.

from pain on moving his arms and legs, when the eruption was at its height, but he slept well, and at no time presented any symptoms of cachexia, or of participation on the part of the general system in the process. Of course, during his stay in the hospital, from time to time new outbreaks of bullæ occurred on various parts of the surface. The lesions were always discrete, not grouped, and they were filled with clear serum. Appearing here and there, when they were left untreated, they underwent those certain changes, which revealed the mode of formation of the various areas and patches already mentioned as being present on the cutaneous surface at the time he came under treatment. It was thus found, that the primary lesion of the process was a tense bulla of variable size—a pea to a filbert—, which arose from apparently normal skin and was not surrounded by any zone of redness. Its contents, at first clear, became at the end of a few hours somewhat cloudy, but yet not purulent, and they would either be absorbed and a crust would be formed, or the rupture of the bulla took place, its walls collapsed and were cast off, and a raw, moist surface was exposed, which would rapidly become dry and scaly, or crusted. In either case, a broad red zone would then develop around the periphery of the lesion and upon it, a continuous bullous ring would arise, or a row of separate and distinct pea-sized bullæ. On the other hand, enlargement of the lesion also occurred through a simple undermining and lifting up, by a small amount of fluid, of the epidermis around the primary and central area, and the formation of a flaccid bullous wall having a sodden, pultaceous aspect.

The lesions having reached this development, they would remain stationary for a time and then undergo involution and healing, or further evolution would take place, and the secondary bullous wall become transformed into a raw, moist, or crusting ring surrounded again by a red zone and a second bullous ring, which would arise upon it. This course might be repeated several times and extension over the surface take place by repeated similar bullous formations in the periphery, or it occurred by progressive undermining of the epidermis. In this way several lesions in close proximity would become confluent and large patches would be formed. On the other hand, the activity of the process in certain places was very great, and the periphery of a lesion would be constituted by several rings of bullæ surrounding a red, moist or scaly crusting center, or, in some instances, the central bulla was still present, and no invo-

lution had taken place prior to the formation of the secondary peripheral lesions. As a consequence of this, patches fully an inch to two inches in diameter would develop, which would resemble a brooch, being composed of a large central bulla surrounded by one or more circlets of discrete and smaller though closely arranged bullæ. Besides these efflorescences, the result of progressive involution and evolution of the primary lesions of the process, there also arose during its course most irregularly shaped bullæ, some linear, others stellate, or resembling a rosette, or having linear projections from various portions of their peripheries. At one time, pustular lesions arose and also secondarily one or two furuncles on the wrists. Crusts, squamæ and excoriated areas were also present, but no scarring or pigmentation remained where the lesions had healed.

The treatment received by the boy was primarily proper hygiene and food and a tonic of iron and quinia. Locally a lotion of magnesia carbonate and oxide of zinc. This latter was continued only for a few days and was changed to ichthyol 3 per cent. in carron oil. Considerable improvement took place, but on February 17th, many lesions having become pustular, a few furuncles having appeared, and there being also much crusting, with pus retention and the temperature 101 deg., baths of  $\text{HgCl}_2$  (1-5000) were ordered every day, and the ichthyol was increased to 6 per cent. Very great improvement followed upon this, but it was observed *regularly, that when the entire surface of the patient was covered with the dressings and bandages that steady involution occurred, but when any part was left unprotected so that the boy could reach it with his hands and scratch the surface, then new bullæ arose upon that part.* In consequence, he was every day dressed after the bath in such a manner as to occlude the entire body, and under this treatment the process steadily declined. The only change made from the ichthyol and carron oil during the existence of the disease, was for a short time to balsam Peru in an ointment. He was also given arsenic internally for some weeks, but without any apparent benefit, the local treatment alone proving to be of any curative value. Unfortunately, no material could be obtained for microscopical examination, except some of the bullous walls, and no cultivation experiments were made to determine the presence or absence of any micro-organic life. The bullous walls showed only the stratum corneum and portions of the stratum mucosum, but beyond this there was nothing satisfactory. In the fluid contents of the bullæ, only a



few white blood-cells were found. We are thus obliged to discuss this case entirely from its clinical symptoms, and we may state that it was a pure bullous eruption, unaccompanied by any participation on the part of the general system in its evolution, and unassociated during its course with any secondary change or disturbance in the general economy, beyond those which for a short time arose as a result of retained and decomposing secretion, crusts, etc., which were allowed to remain on the cutaneous surface. This bullous eruption presented as peculiarities, an eccentric and peripheral extension of its primary lesions, not *exceptionally* but as a *regular feature*, and *pari passu* with their growth, involution of the original and of the subsequent efflorescences, until circinate, rosette and other shaped patches resulted, which existing singly on various portions of the surface, by confluence came to occupy more or less extensive areas. *Distinct autoinoculability* was also observed, whenever any portion of the surface was left uncovered so that it could be reached by the patient and subjected to scratching, etc. When complete involution of the lesions had occurred, neither pigmentation, nor scarring, nor any other apparent change resulted, but complete *restitutio ad integrum* took place.

In the presence of these peculiarities and of the general and other symptoms presented by the eruption, the question of its diagnosis, its nature and its position among bullous dermatoses was of considerable moment, and one which at first sight presented no little difficulty, owing to the confusion existing to-day in regard to bullous diseases of the skin. If the facts alone are considered, that the primary lesion was a tense bulla, arising from apparently normal skin, and that no other efflorescence developed during the entire course of the process, then the diagnosis of pemphigus would be justified. Still, pemphigus vulgaris in its chronic form can be excluded, as it runs a slow and chronic course, and the bullæ, which appear in successive crops, though they may undergo some enlargement of themselves or through confluence with neighboring lesions, yet do not increase in size by progressive peripheral evolution and central involution, as was an essential characteristic of this case. It is also associated with constitutional disturbance and most certainly is not autoinoculable.

Acute pemphigus vulgaris (Febris bullosa) is a rare disease and when it does occur, it is ushered in and the successive outbreaks of its lesions are associated with marked febrile reaction,

cephalalgia, prostration, etc., while albuminuria, and other grave symptoms accompany it. The efflorescences themselves originate upon red macular areas and do not present the clinical features of progressive evolution and involution seen in this case.

In erythema multiforme bullosum we find, in contradistinction to this case, its definite primary localization upon the dorsum of the hands and feet, and more particularly the multiform character of the eruption—papules, papulo-vesicles, bullæ and variously sized erythematous patches being distributed irregularly over the cutaneous surface. The process in some particulars certainly resembled herpes iris, but yet differed from it in its localization, which for the latter disease is primarily that of erythema multiforme and also in its slow course and its inoculability on any part of the body scratched by the patient.

The question of its being varicella bullosa could be scarcely entertained, owing to the entire absence of any of the features characterizing the general course of this disease, while its duration and the manner in which the lesions originated were also entirely different. The same may likewise be said in regard to bullous urticaria, for in it, the bullæ are practically accidental and exceptional formations, few in number, and originating upon pre-existing wheals. Besides, the pruritus is a marked feature and the eruption of transitory duration. I do not think either that this case can be regarded as a true vaccination rash, notwithstanding its development shortly after vaccination, as these follow the type of toxæmic eruptions, are macular, papular, vesicular, sometimes bullous, but never purely so, being more or less multiform in character.

The multiformity and polymorphism characterizing Duhring's disease, even in its bullous form, would also suffice to exclude it from consideration here, while the patient, not having received any treatment prior to his admission to the hospital, the question of its being a medicinal toxicodermia could not be entertained.

According to Besnier-Doyon, the fundamental symptoms of hydroa are malaise, chilliness, anorexia, etc.; primarily a few vesico-bullæ, then rapid eruption of similar lesions and quick evolution of both the disease and the lesion. The latter also run their course *in situ* and do not undergo progressive extension.

The case described here being thus, in my opinion, clinically distinguishable, owing to the symptoms which it presented in

its evolution and course, from these various processes mentioned and characterized by bullous lesions, I would regard the eruption as an example, exaggerated in reality, of impetigo contagiosa bullosa, the pemphigus contagiosus or epidermicus of many authors (Pontoppidan, etc.), one seen especially in children, but also occasionally in adults, and the occurrence of which is very common after vaccination. I would base my diagnosis upon the absence of any distinctive localisation, the evolutive course of the lesions, which occurred throughout its duration, the absence of any secondary cutaneous change, such as pigmentation, etc., the evident autoinoculability of the disease, as shown by its regular development upon any surface left exposed and accessible to the hands of the patient, and its steady retrogression when this was not done, and also the entire want of reaction on the part of the general system, the patient even gaining in general health and in weight during the existence of the process. In view of this latter feature, it cannot but be evident that the disease was a benign one, and this fact, taken in conjunction with the characteristics presented by the lesions, the only parallel to them which I could consider is to be found among those cases of impetigo contagiosa, which appear primarily in the form of bullæ instead of pustules. Such cases are not uncommon, even in connection with and as a sequel of vaccination, though they rarely reach such an exaggerated degree as was seen in this patient. I have met with the disease not only in children, but also in adults. In the former, however, much more frequently than in the latter, and in these almost invariably from apparent inoculation from a child. That is, lesions precisely the same in their mode of origin, development and course as those in the case described here, I have frequently seen on a mother whose baby or child was suffering from the process, the eruption on the former being located on surfaces which came in frequent contact with the lesions on the latter. In these cases, the primary lesion would be a bulla, which would undergo progressive evolution and involution, and form a circinate lesion, or one serpiginous, or gyrate, or polycyclic in outline, indistinguishable except in degree from those which were observed on this boy. Such instances repeatedly seen led me, when examining this patient, to the conclusion that the disease from which he was suffering was only an exaggerated form of this common and banale process, a conclusion verified, in my opinion, by the result of the treatment instituted and based upon that diagnosis, and also

by the observations made upon another and similar case in a girl about 10 years of age, who shortly after was seen by me in consultation with Dr. W. L. Russell. This patient's eruption agreed in every essential detail of origin and course with the one described here, and when some time later, it was presented by Dr. C. W. Allen at a meeting of the New York Dermatological Society, it was likewise recognized by the members present as an exaggerated example of the bullous form of impetigo contagiosa. I do not doubt but that many of the cases of circinate and serpiginous bullous eruptions recorded and etiquetted as peculiar forms of pemphigus vulgaris, owing to the fact that the essential lesion in the process was a bulla, in reality represent the disease from which this boy suffered, and this marked example of impetigo contagiosa bullosa is recorded fully in order to direct attention to the occurrence of such cases, and the necessity of their differentiation from other bullous cutaneous diseases. That such differentiation is important as regards true pemphigus is at least very evident, both as far as its prognosis is concerned and as to its treatment, for with impetigo contagiosa we have to do with a benign and purely local process, in itself of no danger to the general organism, except secondarily from septic absorption possibly, while pemphigus vulgaris is always of grave moment and possibilities, and a disease in which the somatic health is directly concerned. In regard to the treatment, the local and external medication consisting essentially in antisepsis, is the guiding note for the impetigo eruption, while in true pemphigus it is of little account, and what good is sometimes obtained is from systemic treatment—arsenic, tonics, etc. There is thus a very material difference clinically between these two bullous eruptions in the particulars mentioned, and the divergence extends also to the important factors of their etiology and pathology. For, whereas in true pemphigus vulgaris our knowledge of both of these questions is so obscure that it amounts practically to nothing, in impetigo contagiosa there is every reason to ascribe its development to parasitic organisms, both on account of its evident autoinoculability, when a patient is suffering from an attack of the disease, and its contagiousness from one individual to another, and also for the reason that micro-organisms have been found in the contents of its lesions by many observers, though it must be confessed, that a constant and unequivocal parasite has not yet been demonstrated as its definite cause in every case.

14 West Thirty-third Street.



## A CASE OF XANTHOMA DIABETICORUM.

BY

JAS. C. JOHNSTON, A.B., M.D.,

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THE account given by Crocker, in his recent address at Chicago,<sup>1</sup> of a case of xanthoma diabeticorum in which the diabetes was "unsuspected by a well-trained practitioner," and this instance in which the nature of the skin trouble was discovered purely by accident while the glycosuria was under active treatment leads one to suspect that the disease is by no means so uncommon as would appear, and further, that when the urine in every case of xanthoma is carefully and repeatedly examined and the general practitioner receives more training in dermatology, this form will cease to be classed among the rare skin diseases.

The patient, C. W. L. (æt. 57), whom I saw first in October, 1893, with Dr. Frank Abbott, Jr. (I am indebted to Dr. Abbott for the previous medical history of the man), is of interest outside the peculiar field of the specialist in cutaneous diseases, from the number and variety of the ailments to which he has been an unfortunate victim. He came under Dr. Abbott's care on May 2, 1893. At this date his general condition was very poor, examination of his urine showed 8 per cent. of sugar; he was passing from ten to twelve pints daily and he was drinking heavily. Under treatment he showed much improvement until the 1st of June of the same year, when he began a debauch lasting almost the entire Summer. Toward the end of the month he had an attack of heart failure, incipient manifestations of coma appeared, and his life was despaired of. He recovered, however, and under a strict diet the amount of sugar was reduced. A trace of albumen was present during all this time.

Not long after he developed an unsteadiness in his gait, the patellar reflex was abolished, spots appeared before his eyes and shortly his walk became typically ataxic. In consultation it was decided from a history of a suspicious sore some years previous and "some spots on his soles" that the ataxia was due to syphilis. He was placed on specific treatment, and showed marked improvement. His symptoms disappeared, his urine became normal in quantity and contained only  $\frac{1}{2}$  per cent. of sugar. In November he essayed another spree and soon

<sup>1</sup> "Dermatology in its Practical Relations to General Medicine."

became very ill. Four ischio-rectal abscesses were opened and numerous boils appeared, all healing rapidly, as did a cystitis developed at the same time. He is now on mixed treatment, a strict diet, and is in fairly good condition. His urine shows no albumen, but 2 per cent. of sugar and is normal in quantity. Three or four months ago he complained of a slight pain and numbness in his left forearm. Massage was tried with no effect; the power of the limb is being progressively lost, the interossei and palmar eminences show marked loss of substance and it is feared that muscular atrophy has its grip upon him. It is interesting also to note in view of Winfield's article in the November issue of this JOURNAL that he has had repeated attacks of dermatitis herpetiformis, the last of which was disappearing when I saw him first.

The xanthoma appeared early in May, 1893, in the form of a few scattered papules over the elbow. Its extension to other parts was rapid, the back being next involved, then the legs, and last the feet. It was first noticed by the patient after one or two applications of the massage ordered by his medical attendant.

When first seen the eruption was widely disseminated over the surface of the skin, covering the greater portion of the back, the extensor surfaces of the upper arms, both aspects of the forearms, the buttocks, extensor surfaces of the thighs, the legs and both aspects of the feet. The hands are comparatively free from disease, a few lesions only being scattered over their backs. The palms have always been absolutely free from striæ. No lesions were found on the face, chest or abdomen. The patient states that there has never been an eruption on the face or eyelids, two small elevations near the inner canthus of the left eye being congenital. The genitalia, as well as the scalp and buccal mucous membrane are unaffected.

The eruption consisted of papules presenting the usual characteristics of xanthoma, dull red in color, becoming pink as they fade out, discrete or confluent, distinctly hard to the touch, sharply defined, not shading off into the surrounding skin, varying considerably in size from the small lesions of a line diameter to the raised plaques on the soles, half an inch in length by three-eighths in breadth. The yellowish-white apices of the papules were present, as a rule, but quite a number were seen without them and in not a few pressure failed to bring them out. It did not strike Dr. Abbott or myself that the lesions exhibited any predilection for the site of the hair folli-

cles. On the feet, and particularly on the plantar surfaces, there is a marked tendency to grouping into large plates. These plates vary from the size of a silver five-cent piece to that of a quarter. They occur on both feet, along the balls of the small toes chiefly, but appear surrounding in a rough circle, the heel, and on the dorsum of the second and third phalanges as well. They are evidently composed of confluent papules, since the border is serrated and the flat tops present a number of yellow points separated by the red color of the remainder of the disease. The tubercles and plaques are always elevated, on the average one millimetre above the cutaneous surface. They are often traversed by dilated capillaries. The occurrence of a patch under the great toe nail of the right foot gives the patient considerable inconvenience. This case is the first in which involvement of the soles of the feet was noted.

The efflorescence was greatest at this time. The tendency to fade and disappear became apparent shortly, and with the exception of slight exacerbations coincident with, if not due to, fits of intemperance, according to the patient's and our own observation, has steadily progressed. When he adheres rigidly to his treatment, diet, etc., his improvement is noticeably more rapid. At the present time (March, 1894, ten months from its beginning) all that remain, are the plaques and tubercles on the feet and a few scattered lesions on the knees and right wrist. Ulceration has never been a part of the process and the disappearance of a papule leaves absolutely no trace upon the skin.

It will be noticed that the characteristics of the disease (with the possible exception of the occurrence about the hair follicles) correspond exactly with the points of differentiation between xanthoma vulgare and xanthoma diabeticorum mentioned by Sangster and Crocker in their report on Morris' communication to the London Pathological Society; the sudden involution and evolution, the firmness of the lesions, the occurrence of the yellow apices in some only, the absence of striae, the absence of jaundice, the freedom of face and eyelids, the presence of diabetes mellitus. Unfortunately a section of the skin was resolutely refused but a contribution to the histology may be added later. There seems, however, little left to be said on that score, and there is no doubt that the process is what Török in his recent able paper <sup>1</sup> describes it: an irritative

<sup>1</sup> "De la Nature des Xanthomes." *Annals de Derm. et Syph.* November and December, 1893.

process beginning as a round-celled infiltration and ending as a granulo-fatty degeneration with a complete decomposition of the entire tissue totally different from the embryonic connective-tissue origin of ordinary xanthoma. Taking this into consideration with the sharp, clinical points of differentiation, Besnier seems hardly justified in his dictum that they established only the variety of xanthoma, not the non-identity of the glycosuric form with xanthoma vulgare. With its unstable character it does not deserve the name of xanthoma, nor that of lichen, proposed by Sangster and Crocker (l. c.) but rather a term descriptive of its true nature, as Török suggests, a papular eruption of diabetics due to a granulo-fatty degeneration.

*Bibliography.*—So far as I can discover, some seventeen cases, not all of them beyond the possibility of a doubt, however, of this affection, have been reported, three of them in this country. England claims much the largest proportion of examples, nine of the seventeen falling to her share.

Addison and Gull,<sup>1</sup> in 1851, first recognized a transitory xanthoma in the course of a glycosuria. The second case was that of Bristowe,<sup>2</sup> which he called "Keloid of a Rare Form," but which he afterward declared to be a variety of xanthoma, associated with diabetes. The third was reported by Hillairet<sup>3</sup>; a woman with glycosuria. The transitory character is unquestioned.

The fourth was the first of Morris' two cases, "A case of So-called Xanthoma Tuberosum."<sup>4</sup>

Of the fifth there is no written record. It was reported, according to Besnier, to Chambard by Hillairet, the case of a diabetic whose xanthoma disappeared when she consented to forego the pleasures of the table.

Hardaway's paper, "A Case of Multiple Xanthoma, etc.,"<sup>5</sup> gives the history of a cook with xanthoma and glycosuria, but makes no mention of its transitory character. Barlow<sup>6</sup> reported one instance in which there is little room for doubt.

The next two were shown to the Dermatological Society of London by Cavafy and Colcott Fox, Cavafy<sup>7</sup> afterward recording his.

<sup>1</sup> "On a Certain Alteration of the Skin, Vitiligoidea, etc." Guy's Hospital Reports, vol. vii., p. 265.

<sup>2</sup> *Pathological Transactions*. Vol. 17, 1866.

<sup>3</sup> "Étude Clin. et Hist. sur le Xanthome." GENDRE. *Thèse de Paris*, 1879.

<sup>4</sup> *Transactions of the Path. Soc. of London*, 1883, plate xx.

<sup>5</sup> *The St. Louis Courier of Medicine*, October, 1884.

<sup>6</sup> *Brit. Journ. of Derm.* Vol. 1, p. 3, 1888.

<sup>7</sup> *Brit. Journ. of Derm.* Vol. 1, p. 76, 1889.



In March, 1889, Besnier exhibited a patient at a reunion of the physicians of the Hôpital Saint Louis. In the same year, Robinson <sup>8</sup> presented a case to the Dermatological Society of New York which afterward appeared in this JOURNAL and the Atlas of Rare Skin Diseases. In the discussion, Bulkley and Sherwell each claimed a case in their practice which, however, they have not placed on record.

I cannot find the report of Vidal of which Croker makes mention. The next two instances belong to Morris and Croker and will be found in the *Brit. Journ. of Derm.*, August, 1892.

Within the last few months the three remaining cases have been reported in the same *Journal*, one by J. F. Payne, with drawings of the histological appearance of the disease, in which, however, glycosuria was not discovered; one by H. W. Marrett Tims (both in the November number, 1893); the last, a clinical note by S. Pollitzer (December, 1893).

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#### FISH DIET AND LEPROSY.

BY

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THE leprologists of Japan permit their patients the use of the following fish: The Tai fish, *Pagrus tumifrons*, T. & S., *P. Major* and *P. ruber* (*P. Cardinalis*, Lacép most abundant). The Tai is the Japanese name of the scup; it is highly esteemed, so that no feast would be complete without it. It is a bottom fish with a preference for sandy and muddy places. The chief supply of Tai comes from the inland sea, their favorite spawning place. The Tai is eaten fresh and salted.

The Japanese Suzuki, *Percalabrax Japonicus*, T. & S.

The Karei or flounder, *Parophrys cornuta*, Schleg. (*Meita-Garei*), *Pleuronectes Scutifer*, Schleg. (*Ishi-Garei*), *Pl. variegata*, Schleg. (*Hoshi-Garei*), *Plagusia Japonica*, Schleg. (*Ushinoshita-Garei*).

The Hiramé, *Pseudorhombus cuinamoneus*, Schleg. (*Kanzō-Hiramé*), *Ps. Olivaceus*, Schleg. (*Hiramé*). They are both (*Karei* and *Hiramé*) bottom fish; they are mostly eaten raw.

The fish which the Japanese call *Hōbō*, *Trigla kumu*, Less. and Garn.

<sup>8</sup> JOURN. OF GEN. URIN. AND CUTAN. DISEASES. Vol. vii., p. 219.

The Dainan-Hazé, *Gobius hexanema*, Bleek.

The Tārā (Cod), *Gadus Brandti*, Hilgd, *Gadus chalcogrammus*, Pall. (Suketō-Dārā).

It is a bottom fish living at a depth of 500 feet or more and limited to seas which are within the reach of cold currents. The cod feeds on herrings, lampreys, squids and lobsters. Fresh cod is but little eaten in Japan.

The Kochi, *Platycephalus insidiator*, Forsk.

The Hāmo or sea-eel, *Murænesox cinereus*, Forsk.

The Koi is the Japanese carp, *Cyprinus carpio*, L.: it is eaten raw.

The Funa is a small gold carp (*Carassius auratus*, L.) <sup>1</sup>

The Unagi (eel), *Anguilla Bostoniensis*, Ayres. is eaten broiled.

The Dojō (loach) *Misgurnus anguilli caudatus*, Contor.

The Ayu, *Plecoglossus altivelis*, Schleg. is a fresh-water fish, found in sandy rivers all over Japan. It feeds on diatoms and lower algae. It spawns in shallow rapids. It is highly esteemed in the raw state, though it is also eaten broiled.

The Hae (*Temiscus Macropus*).

The Trachurus trachurus (Mā-Aji).

The Caranx muroadsi, T. & S. (Muro-Aji).

The Hemirhamphus sajori, Schleg. (Jap. Sayori).

The Haliotis gigantea Chem. (sea-ear) Jap. Awabi.

The Sciaena sina, C. & V. (Ishimochi).

Lepers are not permitted to eat:

The Tunny fish, *Thynnus sibi*, Schleg. (Maguro or Shibi). *Thynnus albacora*, Lowe (Kiwada-Shibi). It is found in the black stream of the Japanese waters, and never enters bays or inland seas. It is carnivorous, feeding on small fish and squids. It is generally eaten raw (the best of all fish eaten raw), and also smoked and dry.

The Zamé (shark) *Carcharius glauca* (Yoshi-kiri-Zamé), *Zygæna malleus*, Risso. (Shumoku-Zamé.)

*Mustellus manazo*, Bleek. (Hoshi-Zamé.)

*Notidanus Indicus*, M. & H. (Abura-Zamé.)

*Lamna glauca*, M. & H. (Awo-Zamé.)

*Alopecias vulpus*, Gm. (Onaga-Zamé.)

*Rhina squatina*, L. (Kasu-Zamé.)

The Sâké (*Onchorhynchus Haberi*, Hilgd.) is the name of

<sup>1</sup> I attempted last year the cultivation of the lepra bacillus on four of these fishes. I removed scales and inoculated leprous material by puncture; all the fishes died.

the salmon. It is found in the northern parts of Japan, where it enters all the rivers for spawning.

The Māsu (*Onchorhynchus, Perryi*, Hilgd).

The Katsuwo (Bonito), *Thynnus pelamys*, C. & V. *Auxis tapeinosama*, Bleek. (*Sōda-Gatsuwo*.)

These are migratory fishes, arriving in the spring with the black stream, from southern seas. They pass the summer about submarine rocks, near the coast. Their place of spawning is not known. They feed on smaller fish, but cannot be baited with dead fish. The Sōda comes nearer the coast than the Bonito. These fish are also eaten raw.

The Sāba (our mackerel). There are several varieties of it. But *Scomber Colias*, L., is always found in the black stream; it is not known whether he is migratory or not. In its pursuit of prey it enters bays and shallow waters. It eats sardines, small crustaceans, squids and pteropods. It eats salt fish. The spawning takes place in April and May. It is eaten dry, canned and salted.

The Iwashi, our sardine, *Clupea Melanosticta*, Schleg., is a migratory fish, going from South to North in spring, and returning in the autumn. It swims at the surface, feeds on small crustaceans and spawns in the spring. It is mainly used as a fertilizer.

The Konoshiro, *Chatæssus punctatus*, Schleg.

The Aka-Ei, *Trygon pastinaca*, L., and the Japanese Anko, our angler, are considered as indifferent from the point of view of leprosy.

The Japanese Kāki, is the oyster. It is the only shell-fish allowed to a leper.

The following shell-fish are prohibited: The Hamaguri, *Cytherea meretrix* L.

The Baka-Gai, *Macra Sulcataria*, Desh.

The Shijimi, *Corbicula atrata*, Prime.

The Asari, *Tapes Philipinarum*, Adam and Reeve.

The Sazai, *Turbo cornutus*, Gmelin.

The Ta-nishi, the rice field snail, the *Paludina*, fresh-water snail, and the Aka-nishi, *Rapana bezoar*, L., are tabooed likewise, and all dried shell fish.

It must be observed that most of the fish here mentioned are eaten raw. Now the leper villages, of which there are so many in Japan, are generally built on river sides or sea shores, in order to afford the inhabitants an easy manner of getting food. This is to my mind sufficient to prove that leprosy is not a con-

tagious disease. For consider that the infected part of the village population, as well as the healthy persons, mostly relatives, who have joined their fortunes with the lepers, are continually bathing in these waters, washing their clothes in them, wading in them to ply their nets, and last, but not least, throwing into them all their immunditiæ. The fish, necessarily charged with the products of lepers, are eaten raw, at least, to a great extent, by the healthy persons, who have a confidence, presumably founded on experience, that they will not be the worse for partaking of that food.

The number of authors who insist upon the connection of a fish diet with leprosy is considerable, and I think myself that there may be an intermediary-host function between fish diet and leprosy. But how can we explain the fact observed by Unna, that leprosy settles in preference on such parts of the skin as are not bent and unbent by muscular motion, but remain in plump repose?

It seems that, if fish by itself—not, as I think possible, by intermediary-host function—communicates the disease, the mechanically active portions of the skin should not be exempt from contamination. Of course, if a micro-organism was the originator of leprosy, it would be likely to settle in the quiet regions, just as its nearest relative, the tubercle bacillus, establishes itself in the apex of the lungs.

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## Society Transactions.

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### THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO URINARY SURGERY. STATED MEETING, TUESDAY  
EVENING, MARCH 13, 1894.

DR. L. BOLTON BANGS, *Chairman*.

**Exhibition of New Instruments.**—DR. F. TILDEN BROWN exhibited a suspensory clamp which he devised for the purpose of securing the vesico-perineal tube in cases where it is necessary to maintain drainage for some time after perineal section.

DR. BROWN also exhibited a modification of the Clover crutch for perineal operations. In this apparatus the leg pieces are held apart by a right-angled cross-piece instead of a straight bar, and is thus well out of the way of the operator. By means of a spring the cross-piece can be shortened or lengthened at pleasure.



**Tuberculosis of the Kidneys and Bladder.**—DR. WILLIAM G. LEBOUTILLIER presented a specimen showing tuberculosis of the bladder and kidneys, with microscopic sections. The patient, who died on February 27, 1894, was a man, aged 35; married; a nurse by occupation. When he was admitted to the hospital, on December 13, 1893, he was suffering from pulmonary tuberculosis. He stated that some years ago he had his left testicle removed for tubercular disease. His bladder symptoms dated back for some time and he did not know whether they antedated his pulmonary symptoms or not. He complained of frequent micturition, and the urinary sediment showed the tubercle bacilli in great abundance.

At the autopsy the bladder was found to be contracted, and there was a large tuberculous ulcer on its anterior wall. The left ureter appeared to be normal. The right one was considerably dilated and at its widest part it contained a quantity of calcareous material. The pelvis of the right kidney was tubercular and the kidney itself contained a number of cheesy masses. Similar masses were found in the left kidney. A guinea pig was inoculated on December 18, 1893, with three c. c. of the man's urine, and it died on February 15, 1894, from general tuberculosis.

**Report of a Case of Vesical Tumor of Unusual Duration.**—DR. R. F. WEIR gave the history of the case and exhibited the growth removed. The patient was a man, aged 52, who gave a history of intermittent hæmaturia extending over a period of thirty-seven years. He first came under Dr. Weir's observation a year ago last December, and a diagnosis of vesical tumor was arrived at, partly by Guyon's method of having the patient urinate in three glasses, but more particularly by washing out the bladder, and then, with the catheter *in situ*, making a bi-manual examination and exerting pressure on the bladder, so as to force out the blood from the supposed tumor. This latter procedure made the diagnosis very clear. A cystoscopic examination was made, but no tumor discovered. As the hemorrhage was becoming more severe an operation was decided on. The bladder was opened above the pubes; an ordinary round vaginal speculum was then introduced, and through this the inner surface of the bladder was carefully examined. This tumor was found situated just anterior and three-quarters of an inch to the right of the vesical orifice. Without removing the speculum the tumor was seized and cut off close to its base and the Paquelin cautery applied to the bleeding vessels. The growth proved to be a fibro-papilloma. By means of the vaginal speculum, introduced through the supra-pubic opening, Dr. Weir said, the ureters can be readily recognized and a catheter passed into their openings, if desired.

**Specimen of Recurrent Epithelioma of the Bladder.**—Presented by DR. L. BOLTON BANGS.

The patient was a man who, for a period of about seven years before coming under observation, gave a history of intermittent hæmaturia. The attacks of hæmaturia were about one year apart. When he came under observation he had bled so freely that he was in a condition of extreme anæmia. The bladder was opened and a soft growth, papillomatous in character, was removed from the antero-lateral wall of the organ. The patient, who was 67 years of age, made a speedy recovery, and for three years subsequent to the operation he remained in very fair condition. The bladder

was kept in good order by washing. In July, 1892, about three years after the removal of the growth, the patient returned, again complaining of bloody urine. A cystoscopic examination was made and showed a recurrence of the growth at and around the mouth of the left ureter, and the wall of the bladder was infiltrated. It was then suspected that the tumor had assumed a malignant character, and resection of the bladder was proposed. This was refused. The man died about a month ago, and at the autopsy a section of the bladder was removed, showing the epitheliomatous growth. In December, 1893, the man developed a tumor in the left inguinal region, which could be distinctly associated with the bladder and ureter.

DR. WEIR said he has on two occasions resected portions of the bladder for tumor. The peritoneum was first stripped off from the posterior and superior surfaces of the bladder and considerable portions of the organ removed, and the divided surfaces sewn together. The peritoneum strips off comparatively easily, and this gives us an opportunity to cut wide of these malignant growths.

DR. EUGENE FULLER reported that Dr. J. A. Fordyce had completed the microscopical examination of the growth of the penis exhibited by him at the previous meeting and had pronounced it epithelioma.

**Posterior Urethritis.**—DR. F. TILDEN BROWN read a paper with this title. Acute posterior urethritis is rather a complication than a sequence of anterior urethritis. Some think that the auto-infective agent of gonorrhœa is conveyed from the anterior to the posterior urethra, and other portions by means of the lymph channel. Most observers, however, are inclined to believe that the disease traverses to the posterior urethra by continuity. At any rate, between the sixteenth and the twenty-sixth day an extension generally takes place to the posterior urethra. When the bulbous urethra is filled with pus there may be pressure upon it by the clothes or otherwise, which favors its continuance. Locomotive engineers, tailors, oarsmen and bicyclists seem particularly prone to this complication. The paucity of glands, lacunæ and follicles in the posterior urethra as compared with the anterior urethra seem to offer the best explanation of its frequently escaping infection. He had seen several cases in which the fluid has passed into the bladder during irrigation of the urethra with a Kiefer nozzle. Spontaneous extension of an anterior urethritis to the posterior urethra may be expected in a debilitated person. The subjective symptoms may be at first wanting, and hence the condition may for a time be overlooked, and may not be discovered until after the patient again indulges in sexual intercourse, when the sudden reappearance of the discharge may lead him to think that he has suffered a new infection. There is, however, more commonly a sudden development of dysuria and disturbance of the sexual apparatus. Tenesmus is the all-important symptom in posterior urethritis, and there will be urgent demand to urinate which if not immediately attended to will lead to a dribbling of urine. Spermatozoa may be present with undue frequency in the urine, and lead to a suspicion of the existence of a posterior urethritis. In acute posterior urethritis instrumental examination is contra-indicated. By rectal examination by the finger it will be found that pressure upon the prostate gland will cause pain and tenesmus. When the affection is severe there may be marked constitutional symptoms.

Unless the disease be carefully and systematically treated there will be frequent relapses. In the treatment the tenesmus must first be relieved by the use of suppositories or deep injections of cocaine or morphia. The urine should be rendered nearly neutral, using the benzoate of ammonia when the urine is alkaline, or the bitartrate of potash when the urine is acid. Sandal-wood or salol may be administered internally. After the subsidence of the acute symptoms deep urethral injections of very weak solutions of nitrate of silver may be employed.

In chronic posterior urethritis the amount of disturbance is quite variable. In what proportion of cases the gonococci cease to exist is not known, but all such cases should be looked upon as suspicious. To determine whether or not a case is still capable of carrying infection it may be necessary to produce an exacerbation of the disease by the introduction of an irritating solution, for it is well known that gonococci are much more numerous during such an exacerbation. The subjective symptoms are similar to those of the acute form, except that tenesmus is usually absent. The existence of the "comma" thread in the second urine glass is strongly suggestive of chronic disease of the posterior urethra if disease of the anterior urethra can be excluded. If disease of the anterior urethra cannot be excluded, this portion of the canal should be thoroughly irrigated, then the first passage of urine would indicate the condition of the posterior urethra. Deep pressure over the membranous urethra and perineum is more likely to show tenderness than digital examination of the rectum. Here, the urethroscope is exceedingly valuable. At the first examination the lesion is exposed and a three per cent. solution of nitrate of silver applied by means of a specially devised syringe with a cotton tip. This treatment should usually be repeated after two or three days. When the submucous layers are infiltrated, absorption will be promoted and better results obtained by the use of iodine.

DR. E. M. CULVER said that at Guyon's Clinic, in Paris, posterior urethritis was treated by means of instillations of silver nitrate, in different proportions, and by retrojections of permanganate of potash, from one-quarter to one-half grain to the ounce. The bag of a fountain syringe containing a gallon or more of this fluid is suspended at a height sufficient to force the injection from the meatus back through the cut-off muscle and into the bladder. Dr. Culver said that, so far as his own experience goes, he has as yet no reason to complain of the results obtained in the treatment of posterior urethritis by Prof. Ultzmann's method.

DR. GEORGE E. BREWER said that in some cases of posterior urethritis a rather concentrated solution of silver nitrate gives excellent results and may even cut the attack short. In chronic cases he employs a weak solution of silver nitrate, irrigating the urethra in the manner described by Dr. Culver. The receiver should be elevated three or four feet, and a small glass nozzle, attached to the irrigating tube, is introduced into the meatus. Then the patient, who is in a reclining position, is instructed to take two or three deep inhalations, and the fluid usually passes into the deep urethra without any trouble. Dr. Brewer said he considered this method of irrigation preferable to that by means of the Ultzmann tube, and it does away with the possibility of injuring the urethra.

DR. R. W. TAYLOR expressed the view that in the majority of cases of urethritis—certainly in from eighty-six to eighty-eight per cent.—the in-

flammation promptly travels down to the bulb and invades the posterior urethra. The infection extends from cell to cell in the sub-mucous connective tissue; it does not travel by way of the lymphatics, although that is possible. Contrary to the statement of Guyon, posterior urethritis should be regarded as an anatomical extension of the disease, not as a complication. Dr. Taylor said he did not believe that the compressor urethræ muscle had anything whatever to do with preventing infection of the posterior urethra. In many cases coming under his observation the posterior urethra became involved within eight or ten days after the onset of the disease, and during its acute stage, before the use of injections was permitted. The "two-glass test" referred to by Dr. Brown is often deceptive. In sub-acute or chronic cases, in order to locate the site of the inflammation, it is better to first wash out the anterior urethra, or, for quick work, inject into the anterior urethra a dilute solution colored by means of one of the aniline dyes, such as fuchsin.

As regards the bacteriology of posterior urethritis, in the acute form of the disease the gonococci can be found, while in the chronic form they will be absent, or we may find some indifferent form of cocci. An endoscopic examination of the posterior urethra is very difficult and painful. As regards treatment, Dr. Taylor said he preferred making the injections through an ordinary catheter passed into the posterior urethra.

DR. GEORGE K. SWINBURNE said he is in the habit of irrigating the urethra by Guyon's method, having the irrigator placed at a height of about four feet. He has found it very satisfactory, not only in cases of posterior urethritis, but also for irrigating the bladder when the deep urethra is sensitive to the passage of a catheter. In no case has it given rise to any pain. The patient should first be instructed to urinate, and then the anterior urethra should be washed out.

DR. W. K. OTIS said he was inclined to agree with the views expressed by Dr. Taylor regarding the prompt infection of the posterior portion of the canal after anterior urethritis. By means of the endoscope he has frequently noticed the rapid progress of the inflammatory process. For the purpose of irrigating the urethra he did not consider the Kiefer nozzle of any value. Colored injections are very useful in locating the seat of the inflammation, and the information thus gained is much more exact than that obtained by the "two-glass test." The erections suffered by patients with posterior urethritis are very annoying, and he knows of no drug that will prevent their occurrence. The monobromate of camphor and similar remedies have no effect on them. In conclusion, Dr. Otis said that even at the risk of being regarded as a heretic he wished to express the opinion that while many cases of posterior urethritis are infectious, such patients, when they get married, do not, in the great majority of instances, produce endometritis, salpingitis and similar troubles in the female, as has been asserted.

DR. FULLER said that each case of posterior urethritis should be carefully inquired into. A tuberculous individual with inflammation of the posterior urethra may be made much worse if we employ sounds, harsh injections, etc. In very acute cases of posterior urethritis a strong solution of silver nitrate (five or even ten per cent.) often relieves the vesical tenesmus and pain, but occasionally we meet with a case in which it aggravates the symptoms.



DR. H. G. KLOTZ said that whoever has examined the deeper urethra with the endoscope cannot but agree with the statement made that the compressor urethræ does not offer a very strong barrier between the anterior and posterior portions of the canal. The resistance is much more pronounced in the prostatic urethra itself. The muscle appears to have no connection at all with the emptying of the bladder, and he has often doubted that its action is that of a sphincter to that organ. Perhaps it only prevents, in a supplementary way, the outflow of urine. Dr. Klotz said if posterior urethritis occurs as frequently as is affirmed by some writers it seems to have a great tendency to heal under the ordinary methods of treatment applied to the anterior urethra. So far as his experience goes, in the majority of cases of urethritis the inflammation was confined to the anterior urethra. As regards the treatment of acute posterior urethritis, he preferred the use of weak (one per cent.) solutions of silver nitrate.

DR. JAMES P. TUTTLE said that as far back as 1887 he irrigated the bladder in cases where the urethra was unduly sensitive by elevating the irrigator and forcing the water into the bladder by hydraulic pressure. He has found the Kiefer nozzle very serviceable in irrigating the posterior urethra and bladder. As regards the treatment of deep urethral inflammation, he has employed permanganate of potash, in solutions of varying strength, without much benefit. He then employed bichloride of mercury, which is apt to set up an inflammation of the bladder, unless the solutions are very weak. Finally he employed a solution of salicylic and boric acids, about twice the strength of Thiersch's solution, which gave fairly satisfactory results. In old chronic cases the silver nitrate is almost necessary.

**Periurethral Phlegmon near the Frænum (Parafrænitis.)**<sup>1</sup>—By DR. R. GUITERAS.

DR. BREWER said that a few drops of pure carbolic acid injected into the sac of these little abscesses will often heal them up.

DR. OTIS advised opening the phlegmon as soon as it appeared and not to wait to poultice it.

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#### ELEVENTH INTERNATIONAL MEDICAL CONGRESS.

HELD IN ROME, MARCH 29 TO APRIL 5, 1894.

The opening exercises of the congress took place in the Teatro Costanza at 10 o'clock Thursday morning, in the presence of the King and Queen of Italy. The attendance was very large and the spacious theater was filled to its utmost capacity. Many members and delegates were unable to gain admittance on account of the large number who availed themselves of the reduced rates to see the sights of Rome. Unfortunately the utter lack of system which was noticeable at the opening prevailed throughout the entire meeting. Nor was the work in the various sections facilitated by the ordinary care that usually prevails in less pretentious gatherings. Of the four official languages of the congress Italian only was used in giving notices and directions to those who desired to participate. Few of the sections had English-speaking secretaries and in some even French and German were very meagrely understood.

<sup>1</sup> Will be published.

## SECTION OF DERMATOLOGY AND SYPHILOLOGY.

DR. THOMAS DE AMICIS, OF GENOA, *President*.

The *Gonococcus* and its Relation to *Blenorrhagic Inflammations* was the first theme for discussion, opened by Dr. Touton, of Wiesbaden, who maintained that the gonococcus was the *fons et origo* of the disease under consideration, and that a positive diagnosis can be made only by the presence of this micro-organism. It is at the beginning of the attack that its presence is most easily detected, when the disease becomes chronic, as in gleet, a relapse will enable the observer to find the gonococcus, which may not be possible before the onset of the more acute inflammation. Again, Wertheim's culture method may be necessary, especially if extraneous micro-organisms be present. The gonococcus readily passes through mucous epithelium, invading the cellular structures beneath. Again, the lymph channels afford a means of transportation.

DR. ROCA, of Barcelona, spoke highly of lemon juice in destroying the gonococcus, it had, he alleged, a further advantage in that it did not act as a local irritant, as is the case with many local measures.

DR. NEISSER, of Breslau, did not agree with the first speaker that gonococci invaded connective tissue, except in extremely rare instances. He agreed, however, that every doubtful case should be examined for the gonococcus. He further said in his long experience he had never seen the wife infected with gonorrhœa from her husband when repeated microscopical examination had failed to show the gonococcus present. In regard to the clinical appearances of the disease in itself there could be no inference drawn as to the virulency of the affection. The mildest cases often were peculiarly rich in micro-organisms, while a copious discharge may be but slightly infective.

As to the "*tripper faden*," if every man with flocci in his urine were prevented from marrying there would be 90 per cent. who would remain single.

**A Further Contribution on Epidemic Skin Disease.**—DR. THOMAS SAVILL, of London, read a paper with this title. His conclusions were:

I. Its leading features (exfoliation and definite duration) illustrated by fresh cases. Cases in the Paddington Infirmary, 1892; cases in the Paddington Infirmary, 1893; cases in the Fulham Union Infirmary, 1893; cases in the Bethnal Green Workhouse, 1893.

II. That although the disease is undoubtedly, under some conditions, contagious and epidemic, nevertheless it not infrequently occurs sporadically. Sporadic and isolated cases referred to.

III. The cases selected for description in 1891 were chosen for their severity. But many of the original series, and most of those subsequently seen, have been of a much milder, sometimes trivial, type, especially in young persons.

IV. That the disease is not a rare one; and is very liable, especially when mild, to be confused with eczema, psoriasis, etc.

V. That bacteriological researches, since made with the exudation, have failed to isolate the microbe, chiefly on account of the constant contamination with staphylococci.

VII. That the name "*General Exfoliative Epidemic Dermatitis*," sug-

gested by the author in 1892, is an unfortunate one; because (*a*) the disease although always exfoliative, has only sometimes a general distribution; (*b*) it is only epidemic under certain conditions; and (*c*) mild cases hardly amount to a dermatitis.

"Epidemic Skin Disease," the title first used, has the merit of emphasizing the conditions under which the disease first attracted attention.

**Treatment of Ringworm.**—By ALFRED EDDOWES, of London.

After studying Unna's methods in Hamburg the author presented brief notes of fifty cases of ringworm of the scalp treated by himself. He considers chrysarobin to be one of the most useful remedies, and Unna's method of employing it most effective if properly carried out. For out-patient practice in London he has succeeded in simplifying this method in a manner which he described step by step.

Reference was made to what he believes from his own experience to be the common causes of disappointment in the treatment of the worst class of cases. First, and most injurious, is the too prolonged and continuous employment of severe remedies, which produce and maintain a chronic dermatitis; next, insufficient removal of scales and secretion; and lastly, insufficient dressing between the various applications of such remedies as iodine and chrysarobin. In consequence of the large number of rebellious cases with chronic dermatitis which come under his care, and which are not in a suitable condition for the employment of chrysarobin, the author has tried many remedies in a variety of ways. The most useful, so far, have proved to be a combination of tar, salicylic acid and vaseline frequently renewed and the daily washing of the scalp with soft soap, hot water and tar. Tar not only gives substance to the ointment, but like chrysarobin, colors the diseased hairs of fair children and mechanically assists in excluding air from the follicles. The staining of the hair has the obvious advantage of enabling us more readily to estimate the extent and progress of a case. Under this treatment so many bad cases have been rapidly cured as to lead to the hope that it may render the employment of chrysarobin unnecessary as a rule.

Dr. Eddowes formulated the following conclusions:

(1) That when properly treated, children should be allowed to attend school.

(2) We should not impair the physiological functions of the skin, though we may stimulate them.

(3) That the scalp should be, at least from time to time, thoroughly cleansed, so that our remedies may come into perfect contact with the skin.

(4) Air should be excluded as much as possible.

(5) Mercurial, and other poisonous preparations, though frequently very serviceable, should be applied to large surfaces with great caution, and never for a long period together without close supervision.

(6) It seems unnecessary to employ remedies in such a manner as to cause pain.

(7) That it is wise to treat the whole scalp in nearly every case at first, and to pay special attention to rebellious patches later on.

(8) That epilation is almost useless, and probably, when left to nurse or mother, often worse than useless.

(9) That success depends much more upon skill and management than upon the employment of any special remedies.

After having had considerable experience with croton oil as advocated by some authorities he finds himself again returning with increased confidence to the employment of Unna's method, especially for the worst cases.

DR. ABRAHAM, of London, exhibited a device for forcing medicines into the skin under pressure, especially useful in the treatment of ringworm.

**The Nature of Eczema.** PROFESSOR SCHWIMMER, of Budapest, opened the discussion on this subject.

He defined eczema as a superficial catarrhal inflammation of the derma, probably combined with alterations in the nerves. He considered its etiology from a constitutional and local standpoint, and discussed the accidental infection of the eczematous process with micro-organisms.

DR. BREDÁ, of Padua, regarded the micro-organisms found in eczema as secondary, and not the cause of the disease.

PROFESSOR KAPOSI, of Vienna, said we should first separate from true eczema certain affections which are probably due to micro-organisms, such as impetigo contagiosa, eczema marginatum (Hebra), which are found in a skin predisposed to their growth. In regard to true eczema he maintained that it may be provoked in a healthy individual by external irritation, such as chemical, caloric, and dynamic influences, and that a debility of the general nutrition will affect the skin and prevent it from resisting external irritations.

He thinks it better to regard eczema as an inflammation of the skin caused by various chemical and other conditions, and followed by various complications which should not be regarded as causes.

DR. NEISSER looks upon impetigo contagiosa as a distinct disease, but that true eczema may also be due to micro-organisms.

DR. V. PETERSON and many others continued the discussion.

**Cold as an Etiological Factor in Diseases of the Skin,**<sup>1</sup>—DR. WM. T. CORLETT, of Cleveland, next read a paper with this title.

PROFESSOR KAPOSI communicated an interesting case of multiple growth of the scalp, which he regarded as molluscum fibrosum of malignant nature, and showed an excellent wax model of the case.

DR. CROCKER, of London, alluded to a similar case exhibited by Morant Baker, in London, the specimen being now in the Museum of the Royal College of Surgeons. Microscopical examination demonstrated it to be of a sarcomatous nature, although some of the growths underwent involution and disappeared. He hoped that members of the section would have an opportunity to see it and the microscopical sections next year at the International Dermatological Congress, in London.

DR. THIN, of London, spoke to the same effect, and several other members discussed the case.

**Syphilis without Chancre, Syphilis d'Emblee.**—DR. VERCHÈRE, Paris, next read a paper, in which he maintained that repeated observations had confirmed the fact that syphilis may be contracted without the initial lesion.

<sup>1</sup> Will appear in this Journal.



He reported three cases which had been under daily observation, in which no syphilitic lesions were present, yet the subject communicated the disease to others, they likewise presenting no initial lesion.

DR. RIEHL gave an account of his researches on "Pityriasis Versicolor and Erythasma," and exhibited a large number of cultures in series of the *microsporon furfus* and *microsporon minutissimum*.

**The Histological Alterations Caused by Electrolysis in the Removal of Hairs.**—DR. GIOVANNINI read a paper on this subject. He stated that the sebaceous glands were destroyed and sometimes the sweat-glands were also changed.

**The Treatment of Psoriasis with large doses of the Potassium Iodide.**—DR. CHERCHEZ, of Berlad, read a paper with this title. He commenced the treatment by giving three grammes *per diem*, which was increased to 30 or 40 grammes in the twenty-four hours. He had noted good results in several cases.

Several members spoke in disapproval of the treatment.

**Lichen: Its Actual Position Among the Dermatoses.**—The next subject for discussion was opened by DR. NEISSER, of Breslau, who said that the term lichen should be applied to lichen ruber. As subdivisions he would add the lichen (ruber) planus of Wilson, and lichen ruber acuminatus of Hebra and Kaposi. These forms may change so that a single case may present the different varieties of the disease during its course.

Pityriasis rubra (Devergie-Besnier) he regards entirely distinct from lichen and consists of an anomaly of keratization.

Lichen pilaris likewise should not be considered in any way related to the lichen group.

Lichen scrofulosorum he regarded as a misnomer consisting of a para-follicular condition met with in strumous and tuberculous subjects. He preferred the name *scrofuloderma miliare* for this disease.

Lichen urticatus, a term employed by English dermatologists, is, in his opinion, in no way connected with the disease under consideration and should more properly be called *Urticaria papulosa*.

Lichen simplex (Vidal) is the same as the Prurigo of Hebra and is a neurotic condition affecting the vaso-motor and sensory nerves (angiosensibilitäts-neurodermien). Tommasoli has spoken of this disease as prurigo temporaria, and Brocq as prurigo simplex.

MALCOM MORRIS, of London, believed that lichen planus and lichen ruber were identical, and much of the discussion on the subject was a mere play of names. He further said there was no lichen group; that the only lichen was lichen planus and all others modifications of the same.

DR. SCHWIMMER said that lichen planus was a common disease, while lichen ruber was rarely met with. The first question to be solved was whether or not lichen presented a type *per se*. If you observe a single case it will be seen to go through various modifications during its course, and present many of the varieties mentioned in this discussion.

DR. SCHIFF, of Vienna, was of the opinion that the lichen ruber acuminatus is identical with Devergie's pityriasis rubra pilaris, and that this affec-

tion is quite distinct from lichen ruber planus. Much of the present confusion arises from employing the term lichen for all of these conditions.

**Creosote and its Uses**, by DR. FRIEDHEIM, of Leipzig, was the next paper read. He detailed numerous experiments with the drug on animals, as well as on the human subject. He regarded it as useful in the various forms of scrofula and tuberculosis.

**Paget's Disease of the Nose**.—By A. RAVOGLI, of Cincinnati.

After the discovery of the protozoa of the class of the sporozoa described by Leuckart as *coccidium oviforme*, which has been found in an affection of the liver in the rabbit, sporozoa have been found also in the human skin in several affections, which have been comprehended in one class as psorospermoses. Paget's disease of the breast of the woman has been referred to this class after the discovery of coccidia by Wickham and Darier. The writer referred to the following case:

An aged lady presented an ulcerative form affecting the whole nose, extending to the internal corner of the right eye, causing ectropion from cicatricial bands. The ulcerated surface resulted from nodules covered with a whitish macerated epidermis, none or very scanty secretion, and in the middle of the nodules small whitish corpuscles could be detected. A small portion of the affected skin, hardened in alcohol, cut in sections, and stained in hæmatoxylin, showed under the microscope nothing characteristic, except hypertrophy of the epidermic cells and a great infiltration of inflammatory cells among the papillæ and the glands of the skin. But scraping the surface and preparing the detritus in methylblue, large peculiar cells could be detected, among epidermic cells, of an entirely characteristic appearance. These cells are of an oval shape with a double contour, showing a double membrane filled with abundant protoplasm, which has a strong chromatophoric power. In older cells one or two large nuclei can be seen surrounded by small granules. In specimens prepared in glycerine those cells showed amœboid movements.

From the presence of these corpuscles, and from the absence of the characteristic pearls of the epithelioma, it was concluded the case to be one of the Paget disease, with the conclusions as follows:

1. Paget disease is not limited to the breast of the woman, but can also affect other parts.
2. The factor of this disease is the presence of certain organisms, coccidia.
3. It is not an epithelioma, but with time may degenerate into epithelioma.

DR. RAVOGLI'S paper was discussed by several members, among whom Neisser maintained that he believed Paget's disease was not due to the psorosperms, as described in the paper.

**Syphilis, its Curability and Treatment** was then called for general discussion.

DR. JULLIEN, of Paris, spoke at some length, maintaining that in the treatment of syphilis he had found the best results from calomel and the bichloride of mercury given by the mouth or hypodermically. That the method depended largely upon the peculiarities of the patient. Upon the whole, he regarded the subcutaneous method an excellent one, but great

care was necessary in its performance. He emphasized that absolute asepsis should be rigidly adhered to. Further, the toxic effect of calomel was not the same as observed in other forms of mercury. He regarded two and a half years as the usual course of the disease, although one could not speak with mathematical precision.

DR. SCHIFF spoke of the management of the initial lesion, recommending its early excision. By this you "take the bull by the horns," and in his practice he resorts to it when possible. He thought after the disease became established mercury was the only drug to be used as a curative agent, and that three years was the average length of time necessary.

DR. TOUTON did not agree with the last speaker that excision was in any sense a prophylactic measure. From two to four years was the usual time in which mercury, in his experience, was given, and he preferred the injunction to all other methods.

DR. GRÜNFELD, of Vienna, thought, with the last speaker, that excision might not have any positive prophylactic influence, yet in these days of antiseptic surgery it was usually a simple measure, and he often resorted to it. He was positive it did no harm. The only advantage he had found in hypodermic injections was that it was less liable to cause stomatitis.

DR. SCHWIMMER did not agree that from two to four years was the usual course of the disease, he had seen so many cases pronounced cured by some of the members present which after ten years or more presented the disease in various forms. He referred to the disease attacking the nervous system, and thought it was more common than formerly. He prefers to give calomel by the mouth to any other method.

DR. RAVOGLI used the bichloride solution as advised by Auspitz, hypodermically, with good results. He thought by this method the lesions disappeared more slowly than by other means, but the cure was more permanent. He had also found good results from excision. He did not resort to it after induration had taken place.

DR. BRADA did not believe excision did any good.

W. T. CORLETT.

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## Selections.

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### Can the Treatment with Mercury Produce Cylindruria and Albuminuria?

E. WELANDER, Stockholm. (*Archiv für Dermatologie und Syphilis*, 1894, Heft 3.)

Welander was one of the first who claimed that albuminuria or cylindruria found in syphilis is in most cases the effect of the mercury, not of the disease. In this essay he ventilates the question if the elimination of Hg. through the kidneys irritates the latter; and if so, whether this irritation is of a transitory or permanent injury to the renal tissue? He justly remarks that in order to answer this question it is not sufficient to examine the urine for albumen, but it is necessary to make a thorough microscopical examination for casts, and to demonstrate that the latter increase in numbers during the treatment and decrease gradually after the treatment has been discontinued. If syphilis is the cause of the cylindruria the casts are

likely to disappear with the other syphilitic symptoms. Out of ninety-seven cases he found the cylinders slightly in thirty cases, considerably increased in fifty cases during the Hg. treatment. The patients had been examined for casts before the treatment began, with negative results. He furthermore demonstrates that the casts gradually disappear after the cessation of the treatment, and that in most cases they disappear entirely four to six weeks after the treatment has been discontinued. As to the causes which favor the cylindruria mercurialis, constitution, age, predisposition and the severity of the syphilitic symptoms play an important part.

The influence of the different mercurial preparations and the mode of treatment depends on the facility with which the absorption and the elimination of the mercury take place. In the treatment with pills the elimination through the kidneys is very little; therefore, cylindruria rare. In Welander's so-called "*Ueberstreichung*" (spreading mercury on a large area), and in inunctions combined with "*Ueberstreichung*," a considerable elimination takes place twenty-five to thirty days after the beginning of the treatment. In accordance with the elimination cylindruria was frequently found after that mode of treatment. The same is to be said of the injections of Sozodol Hg. If iodide of potassium is given during or immediately after the Hg. treatment no increase of the casts was observed, as would have been expected if iodide actually causes an increased elimination of the mercury. In eighteen cases a distinct causal connection between albuminuria, taking place during the treatment, and the elimination of the mercury through the kidneys was found. In fifteen of these cases there was such a small amount of albumen that it was only detected with the dry 20 per cent. trichloracetic acid test, while at the same time a considerable amount of casts were found. That shows that a microscopical examination is of greater importance than the mere testing the urine for albumen after the usual methods.

The albuminuria does not last as long as the cylindruria after the cessation of the treatment; while the latter is to be found four to six weeks afterwards, the former disappears within a few days after the treatment has been discontinued.

Welander thinks that the irritation of the kidneys caused by the elimination of the mercury is in most cases not of a permanent injury to the patient, but he advises to examine the urine during treatment repeatedly for albumen with a sensitive test, such as the trichloracetic acid test.

If the kidneys are affected before the treatment begins so that the elimination of the mercury through the kidneys cannot take place, the latter is eliminated through the feces, not through the saliva. But even a diseased kidney can eliminate a considerable amount of Hg., but it is always advisable to be particularly careful in cases with an affection of the kidneys, viz., not to use too vigorous a treatment and to examine repeatedly for albumen and casts.

GOLDENBERG.

**The Nature of Xanthomata.** TÖRÖK. (*Annales de Derm. et de Syphil.*, Vol. IV., Nos. 11 and 12, 1893.)

The work deals with the nature and cause of xanthomata, and the relations of the different varieties to each other. These varieties are three: ordinary xanthoma, elastic xanthoma and the xanthoma of diabetics.



*Xanthomata vulgare* is the only species which is found in Besnier's three forms, planum, elevatum et tuberculatum and tuberosum. According to its distribution, it is localized or disseminate. The seat of predilection of the former is almost exclusively the eyelids; of the latter, the neck, palms, fingers, thighs, knees and soles. Török does not recognize the distinction between juvenile and adult xanthoma, for the reason that all the sub-varieties of this form present a single pathological process. Xanthelasmic tissue has a striking analogy to adipose tissue, the analogy being borne out by the cells, which are identical with those of physiological fat in process of formation, further by the formation of these cells around the vessels, in their adventitia even, by the discovery of cells analogous to those of xanthoma in imperfectly developed adipose tissue. (The xanthomatous elements contain their fat surrounded by a fine membrane in the form of little granulations, not as a drop filling the entire cell. The cells have also multiple nuclei.) To explain the arrested development of the cells, the author concludes that ordinary xanthoma is formed of adipose tissue in a heterotopic situation and that it is constituted by reason of that heterotopia of fat cells of incomplete, interrupted evolution, and in some cases to this fat formation must be added that of fibrous tissue.

Among the conditions which provoke the formation of xanthoma are heredity (he cites a remarkable instance where the disease occurred in three generations), a congenital origin and a proliferative hyperactivity of cells tending to fatty metamorphosis. Török then asks if it would not be possible that the hypertrophy of the liver and resulting icterus might be due to the formation of adipo-xanthomatous tissue in the liver? The hepatic condition in reported autopsies has usually been entered simply as hypertrophic cirrhosis, but in a few white patches were discovered on the surface of the liver, its capsule and the numerous membranes of the biliary passages in one instance producing obstruction of the common duct. Consequently, he believes that hepatic derangements in the course of the disease are due to localization of the process in the liver.

From what precedes he concludes that we must regard xanthoma vulgare "as an anomaly produced under the influence of hereditary and congenital conditions by proliferation of connective-tissue cells and by their transformation into fat cells in places which are normally free from adipose tissue. It is an anomaly of formation." Xanthoma must then be called a benign tumor and ranged beside lipoma in the group of anomalies due to excess of production. Next is appended a tabulated review of thirty cases of juvenile and forty cases of adult xanthoma of this form.

There is little to be said of *elastic xanthoma* due to the fact that only two cases of the affection have been reported. The alteration is essentially in the elastic tissue which forms in the derma, near the border of the plaques, considerable collections, discrete or confluent, surrounding a hair follicle. The fibres are larger than normal, some of them, fragmented with no cell-infiltration. The localization differs from disseminated xanthoma in that the extensor surfaces remain free. It occurs in macular form on the neck, back, folds of the flexures and eyelids. Török regards it as a true xanthoma vulgare, merely a plane variety due to retrogression.

This is not his view with regard to *xanthoma diabeticorum*, however, to which he gives up the entire second installment of his paper. He classes it as a distinct affection which has no relation to the common form. He

reviews the clinical differential points enumerated in Crocker and Sangster's report and claims that, from this point of view as well as from microscopical examination, one must suspect some irritative process. Briefly, these appearances consist in a vascular dilatation, a slight œdema, a round-cell infiltration and the presence of fat in drops of different sizes not contained solely in the cells, but taking the place of them and connective tissue, forming a confluent mass in the center, so that an entire central degeneration must be recognized. "The lesions of xanthoma diabeticorum are caused locally by an irritative process, ending in a granulo-fatty degeneration." As to that process and the relation to glycosuria, he does not pretend to an opinion. The disease should have a distinctive name, and dismissing the present one and lichen, the author contents himself for the present with "a papular eruption of diabetics due to fatty degeneration." A table of the first seven cases closes the paper.

JOHNSTON.

**The Nature of Xanthomata and the Proximate Cause of their Complications.**  
H. HALLOPEAU. (*Annales de Derm. et de Syphil.* Vol. IV., No. 8, 1893).

The author, after presenting a case of transient xanthoma, without a trace of glycosuria after repeated examinations, draws from his own experience and that of others, these conclusions, which we cannot do better than give in his own words.

1. Xanthomata are benign neoplasms of embryonic origin, *i.e.*, nævi, according to the newly formulated conception of these tumors.

2. They may be localized, as Koebner has shown, in a region occupied by a nævus.

3. They may form long bands following the course of nerves, a characteristic disposition of nævi.

4. They are due, conformably to the views of Touton, to the persistence in the tissues and the proliferation of embryonic cells, capable of fat formation.

5. They may secondarily become the seat of exudation, hyperæmia or hemorrhage.

6. Tumors of the limbs, being very vascular, may be effaced to the point of becoming almost unrecognizable.

7. The icterus which accompanies xanthoma is due, according to Kaposi, to their extension to the biliary passages.

8. The glycosuria which in a number of cases has coincided with it, is due, from analogy, to another visceral localization of the lesions; the pancreas is the probable site. (The author regards the xanthoma as the primitive process.)

9. This visceral localization is especially observed when the xanthoma occupies the body in the form of punctate tuberosities (*tubérosités punctuées*).

10. The existence of macules in the neighborhood of tumors shows that they are susceptible of undergoing retrograde evolution; this fact and also the possibility of change of size according to the degree of repletion of the vascular system explains the intermittences of icterus and glycosuria with which the disease may be accompanied.

JOHNSTON.

**Transverse Suprapubic Cystotomy.** (*Annales des Maladies des Organes Génito-Urinaires*, Février, 1893.)

ALBARRAN, having had experience in six cases with this method of operating, concludes that it is no more dangerous than the ordinary longitudinal procedure. The special danger which attends it lies in the tendency which the bowels have to protrude in case there is much straining after the operation. The author, however, thinks that this danger can be guarded against successfully should the divided muscles and fasciæ be properly united by sutures. This form of operation is advocated in preference to the longitudinal cut for prostatectomy, for the removal of tumors occupying the lower segment of the bladder, for cases where it is impossible to distend the bladder, as in rupture, or where the organ is bound down by adhesions, and for cases where the peritoneum remains fixed just above the pubes, as often occurs with individuals who have already, at some previous time, had to submit to a suprapubic incision. The transverse incision is contra-indicated in children, in cases complicated by double inguinal hernia, and in cases of stone and foreign bodies.

EUGENE FULLER.

**Infection of the Bladder by Germs from Neighboring Organs.** (*Annales des Maladies des Organes Génito-Urinaires*, Avril & Mai, 1893.)

EMILE REYMOND shows that under certain favorable conditions germs can enter the bladder through its walls and the intervening tissues, their origin being some neighboring focus of inflammation, such as may exist in the lower bowel, the womb or the pelvic connective tissue. Numerous experiments were made with dogs, ligatures being applied about the penis to occasion stagnation of urine at the same time that a selected variety of germs were injected into the perivesicular tissues. After a number of hours these germs were found in the bladder. Many clinical cases were cited to prove the assertions. In a number of these cases the same germ was found; for instance, in the bladder and in the womb. After the inflammatory focus in the womb had been cured the germs would be found to have promptly disappeared from the bladder.

EUGENE FULLER.

**Electrolysis.** (*Annales des Maladies des Organes Génito-Urinaires*, Août, 1893.)

E. DESNOS treats the subject of electrolysis for the cure of stricture most thoroughly. Part of the article is devoted to the results of experiments on dogs. In some of these cases traumatic strictures were produced, and then later attempts were made to cure these lesions by electricity. In other instances the effects of the application of varying intensities of electricity on the normal urethral mucous membrane were investigated. Besides this the clinical results in the cases of forty-six men are given. Some of these were treated by Neumann's method, with weak currents, and others by Fort's method, with very strong ones. As the result of these careful and useful investigations Desnos concludes that weak currents, used according to the Neumann method, may be of some value in certain cases, but that the improvement is so slow (in some instances weekly treatments for a year being required) that it is not practical, and that strong currents are posi-

tively injurious, the site of their application being followed by traumatic strictures associated with a dense cicatrix, it making no difference whether the urethral mucous membrane was normal or pathological before the strong current was applied.

EUGENE FULLER.

**Complete Suture of the Bladder After Suprapubic Cystotomy.** SOREL.  
(*Thèse of Paris*, 1893.)

In this thesis the author, an interne at the Necker Hospital, concludes that complete suture of the vesical walls ought to be attempted in all cases except those in which there exists, in connection with the vesical walls, extensive traumatism, pathological modifications or hæmorrhage.

EUGENE FULLER.

**THERAPEUTIC NOTES.**

**Benzoin.**—This drug, in the form of the compound tincture, either in combination in ointment or pure, has been found to be of considerable service in the treatment of seborrhœic eczema. Alone it is also of great value in chronic eczema of the eye lids and lips of any origin.

**Rubber Plaster.**—P. COUSIN recommends the use of caoutchouc coverings, applied according to the method of Dr. Tenneson, in eczema. He seems to regard it as a panacea in all forms of the disease. (*Thèse de Dermatologie*, 1893).

**Alumol** has, according to Heinz and Liebrechte, a marked antiseptic and astringent action. It is efficacious, in the form of pencils, in blenorrhagic endometritis; in skin diseases attended by chronic inflammation, Chotzen gives it a more extended notice. He used it in powder, solution, spirit, ointment, plaster or oil, and in a great variety of affections, ulcers, parasitic and microbic diseases, psoriasis, prurigo, eczema, lupus, etc., with marked success. In a 1 per cent. to 20 per cent. solution as an injection, it is claimed to be "almost a specific in gonorrhœa" in the male. (*Berliner Klin. Wochenschrift*.)

**Euophen** has been employed by William S. Gottheil in the form of ointment with good results, in tertiary syphilitic ulceration, in chromophytosis and trichophytosis circinata. In seven cases of chronic eczema all were ameliorated, two cured; in the acute form it is much less efficacious. In venereal ulcers its action is more rapid than iodoform.

**Sodium Ethylate.**—GAMBERINI and MOUARI claim to have cured psoriasis in twenty days by frictions with a liniment composed of

Sodium Ethylate.....	20 gr.
Olive Oil .....	80 gr.

It was used with effect in lupus vulgaris, Paget's disease and torpid ulcers.

**Sulphophenate of Sodium.**—SPIEGLER has obtained good results in prurigo with this drug in 5 to 10 per cent. ointment, using equal parts of vaseline and lanolin as a base. It is non-toxic, provokes no irritation.



**Resorcinol** (a compound of resorcin and iodoform) has given Biëlaiew satisfaction in treatment of chancre, ulcer of the leg, eczema, psoriasis, lichen, etc. It calms pruritus immediately, but should be well diluted in powder, 10 per cent. is the ordinary ointment strength. (STRAUSS, *Monat. für Prakt. Derm.*)

JOHNSTON.

## Items.

**Programme of the American Association of Genito-Urinary Surgeons.**—Eighth Annual Meeting, to be held at the Shoreham Hotel, Washington, D.C., May 29, 30, 31 and June 1, 1894.

1. Modifications of Bigelow's Operation for Stone in the Bladder designed to meet Cases in which the Prostate is enlarged. By George Chismore, of San Francisco, Cal.

2. The Treatment of Hypertrophied Prostate. By J. William White, M.D., Philadelphia, Pa.

3. Report of some Cases of Rupture of the Urethra. By Francis S. Watson, M.D., of Boston, Mass.

4. Remarks on the Treatment of Cystitis. By Gardner W. Allen, M.D., of Boston, Mass.

5. Aero-urethroscopy with a New Instrument. By William K. Otis M.D. of New York City.

6. Stone in the Bladder. Choice of operation. By William H. Kingston, M.D., Montreal, Canada.

7. Urine-Leakage and Stricture Formation. By John P. Bryson, M.D., of St. Louis, Mo.

8. The Possibility of Overcoming Permanent Stricture of the Deep Urethra without Resort to External Urethrotomy. By J. Blake White, M.D., of New York City.

9. The Surgical Aspect of Impotence. By Edward R. Palmer, M.D., of Louisville, Ky.

10. Epithelioma of the Penis. By Edward Martin, M.D., of Philadelphia, Pa.

11. The Hygiene of Circumcision. By W. Frank Glenn, M.D., of Nashville, Tenn.

12. The Question of Surgical Interference in Tuberculous Kidney. By John P. Bryson, M.D., of St. Louis, Mo.

13. Report on Irrigation of the Bladder and Urethra without a Catheter. By George E. Brewer, M.D., of New York City.

14. Catheterization of the Ureters in the male. By William K. Otis, M.D., of New York City.

15. Exhibition of Calculus from the Kidney. By Edmund E. King, M.D., of Toronto, Canada.

Afternoon Session at Metzert's Music Hall, corner Twelfth and F Streets, N. W. From 2 to 3.30 P. M. General Session of the Congress under the direction of the American Association of Genito-Urinary Surgeons.

Nephritis in its Surgical Aspects. Opened with a paper by Edward L. Keyes, M.D., of New York City, followed with a paper by George M. Sternberg, M.D., Surgeon-General United States Army, on the Bacteriology of

Nephritis, and discussed by George Chismore, M.D., San Francisco, Cal.; L. Bolton Bangs, M.D., New York City; Francis S. Watson, M.D., Boston Mass.

16. Some Infrequent Symptoms of Disease of the Urinary Tract. By Alexander W. Stein, of New York City.

17. The Relationship of Syphilis to Stricture of the Rectum. By Robert W. Taylor, M.D., of New York City.

18. Two Cases of Syphilis having a bearing on the question of the period during which the disease is communicable. By James Bell, M.D., of Montreal, Canada.

19. Excision of the Initial Lesion. By Edmund E. King, M.D., of Toronto, Canada.

20. Brief Report of a Case of Cystitis and Pyelo-Nephritis due to the Colon bacillus, requiring Nephrectomy. By F. Tilden Brown, of New York City.

21. New Instruments and Apparatus. By F. Tilden Brown, of New York City.

J. A. FORDYCE, *Secretary*.

#### AMERICAN DERMATOLOGICAL ASSOCIATION.

Programme of the Eighteenth Annual Meeting to be held at Washington, D. C., May 29, 30, 31, and June 1, 1894.

Address by the President, D. R. B. Morrison.

Thyroid Feeding in Diseases of the Skin. By Dr. G. T. Jackson.

A Case of Favus of the Head and Body. By Drs. J. A. Cantrell and E. J. Stout.

The Rare Forms of Alopecia. By Dr. G. H. Fox.

Ichthyosis-Congenita (so-called Harlequin Fœtus). History of a Case Still Living. By Dr. S. Sherwell.

The Pathological Anatomy of Pearly Epithelioma of the Face. By Dr. J. A. Fordyce.

The Question of Contagiousness of Molluscum Contagiosum. By Dr. H. W. Stelwagon.

The Therapeutic Value of Urea in the Treatment of Skin Diseases. By Dr. C. W. Cuttler.

Angioma Serpiginosum and Some Other Rare Dermatoses. By Dr. J. C. White.

Dermatitis Exfoliativa. General Discussion.

Paper to be announced. By Dr. E. B. Bronson.

The Relation of Impetigo Hepetiformis to Pemphigus Vegetans. By Dr. J. Zeisler.

The Protozoa-like Bodies of Herpes Zoster: a Contribution to the Study of Psorospermiosis. By Dr. M. B. Hartzell.

Acquired Idiosyncrasy for Quinine, with Peculiar Cutaneous Manifestations. By Dr. C. W. Allen.

Cold as an Etiological Factor in Diseases of the Skin, with Report of Cases. By Dr. W. T. Corlett.

Notes on Drug Eruptions. By Dr. J. A. Fordyce.

CHARLES W. ALLEN, *Secretary*.

## GERMAN DERMATOLOGICAL SOCIETY.

The Fourth Annual Meeting will be held at Breslau on the 14th, 15th and 16th of May, 1894.

The principal subjects announced for discussion are:

1. The Modern Attempts at Systematizing in Dermatology, introduced by Prof. Kaposi, of Vienna.

2. The present position of our knowledge of Dermatomycoses, introduced by Prof. Pick, of Prague.

Besides these a large number of papers and clinical demonstrations have been announced.

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## Books and Pamphlets Received.

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Beiträge zur Ätiologie, Prophylaxe und Therapie der Cystitis. Von R. Barlow. (Seperat-Abdruck aus dem *Archiv f. Derm u. Syph.*, 1893.)

Ein Dermatologisches System auf Pathologisch-Anatomischer (Hebraischer) Basis. (Dermatologische Studien). Von Dr. S. Jessner. Hamburg und Leipzig, Verlag von Leopold Voss.

Syphilis und Prostitution von Standpunkte der öffentlichen Gesundheitspflege. Von Dr. A. Blaschko. Berlin, Verlag von S. Karger, 1893.

Die Zaraath (Lepra) der Hebräischen Bible. Von G. N. Münch. Hamburg und Leipzig, Verlag von Leopold Voss, 1893.

Lectures on Auto-intoxication in Disease, or self-poisoning of the Individual, by Ch. Bouchard, Paris: Translated, with a preface by Thomas Oliver, M.A., M.D., etc. Philadelphia: The F. A. Davis Co., 1894.

Superfluous Hair and the means of removing it, by Balmanno Squire, M.D. London: J. & A. Churchill, 1893.

The Structures in the Mesosalphinx; Their Normal and Pathological Anatomy, by J. W. Ballantyne, M.D., etc., and J. D. Williams, M.D., etc. Edinburgh: Oliver & Boyd, 1893.

Die Blennorrhæ der Sexualorgane und ihre Complications. Dritte Auflage. Von Dr. Ernest Finger. Leipzig und Wien: Franz Deuticke, 1893.

Symptomatologie und Histologie der Hautkrankheiten. Von H. Leloir und É. Vidal. In Deutschen Bearbeitung von Dr. Edward Schiff (Wien). Lieferung, 2, 3 and 4. Hamburg und Leipzig: Verlag von Leopold Voss.

The Treatment of Malignant Cutaneous Epitheliomata, by A. R. Robinson, M.B., etc. Published by the International Journal of Surgery Co., New York.

Was ist Eczem? Von Dr. Med. Ernst Kromayer. Halle: Verlag von Tausch & Grosse.

A Pharmacopœia for Diseases of the Skin. Edited by James Startin. Third Edition. London: H. K. Lewis.

A Practical Treatise on Diseases of the Hair and Scalp, by George Thomas Jackson, M.D. Second Edition. New York: E. B. Treat, 1894.

A Practical System of Studying the German Language. For Physicians and Medical Students, by Albert Pick, M.D. Parts I. to IV. Pick & Tanner, Newtonville, Mass.

- Traité Descriptif des Maladies de la Peau. Par H. Leloir et Émile Vidal. Livraison, 5 et 6. Paris: G. Masson, Éditeur, 1893 and 1894.
- Acromegaly, by Archibald Church, M.D., and William Hessert, M.D. (Reprinted from *The Medical Record*, May 6, 1893.)
- The Treatment of Anorectal Fistula, by James P. Tuttle, M.D. (Reprinted from *The New York Medical Journal*, July 1, 1893.)
- The Pernicious Influence of Albinism upon the Eye, by George M. Gould, M.D. (Reprinted from *The Annals of Ophthalmology and Othology*, Vol. II. No. 3, 1893.)
- Irrigation of the Urethra and Bladder, by Posture and Continuous Current, by B. M. Daggett, M.D. (Reprinted from *The Buffalo Medical and Surgical Journal*, March, 1893.)
- Excision of Cancer of the Rectum, by Andrew J. McCosh, M.D. (Reprinted from *The New York Medical Journal*, September 3, 1892.)
- Suprapubic Lithotomy, by Edmund E. King, M.D. (Reprinted from *The Canadian Practitioner*.)
- Movable Kidney; with a Report of Cases Treated by Nephrorrhaphy, by George M. Edebohls, M.D. (Reprinted from *The American Journal of the Medical Science*, March and April, 1893.)
- The Rôle of the Posterior Urethra in Chronic Inflammation, by Bransford Lewis, M.D. (Reprinted from *The New York Medical Record*, 1893.)
- A Suggested Improvement in the Correction of Lenses for Photomicrography, Photography and Photastrography, by Henry G. Piffard, M.D. (Reprinted from *The American Journal of the Medical Sciences*, July, 1893.)
- Clinical Notes on Chancre of the Tonsil, by L. Duncan Bulkley, M.D. (Reprinted from *Transactions of The Medical Society of the State of New York*, 1893.)
- The Cystoscope in Obscure Bladder Troubles, by L. J. Krouse, M.D. (Reprinted from *The Ohio Medical Journal*, July, 1893.)
- Medical Report of the Philadelphia Dispensary for Skin Diseases, by Henry W. Stelwagon, M.D.
- Traitement de la Blennorrhagie par les Lavages au Siphon. Par Le Docteur Émile Delaroche. Paris: Société d'Éditions Scientifiques, 1893.
- Purpura Recurrens, Von A. Ravogli, M.D. (Sonder-Abdruck aus *Monatsheft. f. prak. Derm.*, 1893.)
- The Treatment of Eczema, by A. Ravogli. (*The Cincinnati Lancet-Clinic*, December 9, 1893.)
- Concerning the Etiology of Eczema, by A. Ravogli, M.D. (*Medical News*, January 13, 1894.)
- Alopecia Præmatura: Its most frequent cause Eczema Seborrhoicum, by George T. Elliot, M.D. (Reprinted from *The New York Medical Journal*, February 4, 1893.)
- The Third Year's Work at the Clinic for Diseases of the Rectum, in the New York Post-Graduate Hospital, by Charles B. Kelsey, M.D. (Reprinted from *The New York Medical Journal*, February 18, 1893.)
- The Internal Treatment of Lupus Erythematosus with Phosphorus, by L. Duncan Bulkley, M.D. (Reprinted from *The American Journal of the Medical Sciences*, April, 1893.)
- On The Relation of Eczema to Diseases of the Nervous System, by L. Duncan Bulkley, M.D. (Reprinted from *The Medical News*, 1891.)



# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

PERSISTENT URETHRAL DISCHARGES DEPENDENT ON SUB-  
ACUTE OR CHRONIC SEMINAL VESICULITIS.<sup>1</sup>

BY

EUGENE FULLER, M.D.,

New York.

FORMERLY oftener than at present it was customary in medical literature to find mention made of a class of urethral discharge which were so rebellious under all known and approved forms of treatment that the most efficacious plan seemed to be to leave them alone to recover as best they could. Many such cases would finally get well of themselves, but in the great majority of these instances the person afflicted would be positive that something or other which he had done generally in desperation had cured him.

In a respectable percentage of these individuals the extraordinary alleged curative agency would be sexual or alcoholic excess or, and as very frequently happened, a combination of the two. Since the introduction of deep urethral instillations and of the electrical illumination of the urethra through the endoscope, permitting topical applications to be made, cases of so-called incurable urethral discharges have wonderfully diminished; but still a goodly number exist, as evidenced by the many chronic cases one sees, which have been the professional rounds without relief.

I flatter myself that I have been able to cure, at least apparently, and as thoroughly as one can ever claim to cure a chronic urethral discharge, a certain number of these cases which at

<sup>1</sup>Thesis presented for membership to the American Association of Genito-Urinary Surgeons at the May, 1894, Meeting, held in Washington.

my own and at the hands of others had resisted all the usual forms of treatment.

In treating a number of them I was aided by the valuable advice and co-operation of Dr. Keyes, and it was from him originally that I obtained the ideas which I have endeavored to develop. A consideration and classification of these cases, their histories more or less minute according to the points of interest presented, together with some comments, are the objects of this paper.

During my earlier investigations with reference to vesiculitis, usually undertaken in the cases of individuals who presented symptoms indicating a disturbance of the sexual function (see article on Seminal Vesiculitis in the September, 1893, number of THE JOURN. OF CUTAN. AND GEN. URIN. DIS.) I was impressed with the fact that in a certain percentage there co-existed a urethral discharge oftentimes somewhat intermittent in character, generally scanty in amount, although occasionally profuse. Inquiry disclosed the fact that a number of these individuals had already sought treatment for these discharges almost invariably without success.

As the vesicles in these cases presented the chief focus of disturbance all treatment was directed toward them, little or no attention being paid at the time to the discharge. As, however, the vesicles got better it was observed that the discharge oftentimes also disappeared. These facts, together with the instances already alluded to, a number of which had come under my personal observation, where patients tiring of a tedious and apparently futile treatment for a chronic discharge, had broken the rules laid down by their medical advisers, and indulged freely in sexual intercourse, resulting in the cure of their complaint, led me to investigate the condition of the seminal vesicles in all cases where a discharge had proved itself rebellious to the ordinary modes of treatment, even though there were apparently no co-existing sexual derangements.

Within the last two years, during which time I have been actively investigating this subject, I have seen quite a number of cases which apparently were of the class under consideration, but in this article it has seemed best to notice only such of them as remained under my personal supervision for a considerable interval, and concerning the final outcome of which I am well acquainted, all transient cases and those simply seeking a diagnosis with instructions being discarded. The cases thus left for consideration number twenty-two. Of these, seven

were evidently tubercular in character, and will be considered last of all by themselves, the fifteen representing simple inflammatory conditions coming first.

In most of these fifteen cases the origin of the inflammation was gonorrhœal. In some of them that disease was the immediate cause of the vesiculitis, though commonly it was found to be the cause more or less remote. All but one of the fifteen acknowledged having had gonorrhœa at some time or other; although a number of those admitting a former clap did not themselves ascribe their existing trouble to that source.

In twelve of the fifteen cases, as the result of treatment, all signs of discharge have disappeared, although in several of these twelve cases some signs of vesiculitis still exist, it having been observed that ordinarily the discharge ceases before complete resolution in the vesicles has taken place. On this account some patients consider themselves cured when the discharge stops, and consequently become careless or neglectful of further treatment directed toward the final cure of the vesiculitis. Of the remaining three cases, all very chronic in character, one is slowly but steadily improving, one is irregular in attendance, easily discouraged, and although somewhat better is not relieved, and one, an elderly gentleman, with considerable accompanying chronic prostatic hypertrophy, showed no signs of improvement after numerous treatments.

During the active stage of treatment patients should be seen once in every five to seven days. The active stage of treatment lasts all the way from a month to six weeks, in the most favorable cases to eight or nine months, and possibly longer in the severe and chronic ones. During the active stage of treatment in some cases where there is a tendency to an inflammatory reaction, it may be beneficial to suspend treatment for a month or six weeks.

After resolution in the vesicles has been sufficiently established (*i.e.*, after the muscular tonus has been restored) it is still well, as a precautionary measure, to examine these organs at least once a month for a period of from four to six months, in order to make certain that they do not tend to relapse into their former state, thus rendering a return of the discharge possible. The peculiar mode of treatment adopted in these cases, which consists of stripping the diseased vesicles of their contents by means of the fore-finger in the rectum, has been fully described in my article on seminal vesiculitis, reference to which has already been made.

As, however, some confusion seems still to exist in the professional mind regarding this point, it has seemed well at the present time to make further remarks on this subject. In the first place, there has been a tendency to confound this treatment with that of the so-called "prostatic massage," which form of treatment has been advocated, off and on, for a number of years, in a rather random manner, by a few Continental writers, chiefly Russian, for certain vague prostatic conditions, mainly neuralgias, such as may persist after the subsidence of inflammatory conditions, and in old men to reduce chronic prostatic hypertrophy, the object being to improve the circulation in the parts with the hope of promoting absorption. In a good percentage of cases where I have delegated this stripping of the vesicles to others, and in which, after an apparently sufficient interval, no improvement took place, I found that the attending surgeon had not grasped the idea of stripping the vesicles, but had simply massaged the prostatic region. By so doing little or none of the inflammatory vesicular material was pressed out, but rather churned up, as it were. Consequently the vesicular contents instead of being reduced were more apt to be increased by reason of the disturbance produced, and thus oftentimes the condition of the patient was aggravated rather than relieved.

In a number of these cases, with the consent of the attending surgeon, I subsequently undertook the treatment with the result of speedily relieving the symptoms. In all such cases the patients remarked that my manipulations produced sensations entirely different from those they had previously experienced during their former treatment.

Then, again, a number of surgeons have declared to me that such treatment could be successfully executed only by those who happened to have a long fore-finger, and consequently an extensive reach. This is the same argument which one hears so often advanced against the short-armed man in the boxing match. Still, if the short-armed man has only the requisite skill, it is seen that he has no difficulty in reaching all the vulnerable parts of his long-armed antagonist. I take it that the fore-finger of most adults is long enough. In fact the real obstacle to success does not lie in the length of the fore-finger, but in the ability of the operator to overcome the natural resistance of the perineal muscles. When a case is first treated this muscular resistance is liable to be very marked. As, however, the patient becomes by degrees accustomed to the manip-



ulations, and as the vesicular tenderness decreases, this element of muscular resistance diminishes. On this account it is always well with a new case to be as gentle as possible in executing treatment, otherwise what is simply a disagreeable sensation may be looked upon as an ordeal.

If a patient continues in this latter mental state the muscular tension is always intensified and manipulations may be very difficult. To overcome this muscular resistance, firm pressure with the closed fist minus the extended fore-finger against the perineum is necessary. In some thick-set, rigid individuals the perineal pressure required may be very considerable, since in such instances counter pressure on the hypogastrium with the other hand accomplishes but little.

In such cases the muscular effort required to enable the fore-finger to perform the necessary stripping may be greater than an operator who is not physically fairly robust can command. As an aid in making perineal pressure where much resistance is encountered, I have found that the knee corresponding to the arm, used in manipulating, can be made to play an important auxiliary role in pushing against the elbow. In order to carry out this maneuver a chair is drawn up behind the patient as he stands with his body bent forward in what I have been accustomed to term the "leap frog" position, and ready for the treatment. Then the foot of the operator corresponding to the hand to be aided is placed in the chair, thus bringing the knee up to the level of the elbow. By this arrangement the muscles of the thigh and leg, as well as of the arm and shoulder, all working together can furnish pressure sufficient to overcome the resistance of the most rigid perineum. It is only occasionally that such extensive muscular efforts are called for. In weakly, loose-fibred individuals little or no perineal pressure is required to reach the vesicles, or, even if need be, much further. In fact, in such cases with a little counter-abdominal pressure one can easily engage the tip of the fore-finger in the sigmoid flexure.

*Cases.* I.—twenty-five years old, had gonorrhœa three years ago, and had never been well since. He complained of a relapsing urethral discharge, associated with a burning sensation along the urethra, and a pain above the pubes. After being very careful of himself for a time the discharge might disappear, though the painful sensation did not. Upon the least indiscretion, however, the discharge was liable to reappear. Since this trouble he had been sexually weak. He had tried all kinds of

internal remedies, anterior and deep injections, besides having had his anterior urethra extensively cut for alleged large-calibre stricture. All this treatment had failed to relieve him. In fact, he considered that the sounds used after the urethrotomy had made him worse than before the operation. Examination of the urine showed numerous urethral shreds and considerable free pus, chiefly, however, from the deep urethra. A large-sized blunt steel sound entered the bladder with no resistance and detected but little tenderness. Rectal feel showed both vesicles, especially the left, to be tender, indurated and distended. Systematic strippings of the vesicles, associated with an occasional vesical lavage of corrosive sublimate in solutions of from 1-12000 to 1-10000 accomplished a cure in about two months, at the end of which time the gentleman married.

This case would, I expect, have recovered without the association of the lavage, but as it was one of my earlier ones, and as time was an object, it was thought better not to depend wholly upon the vesicular manipulation.

II.—twenty-nine years old; contracted gonorrhœa a year and a half before consulting me. During all this time he had had a very abundant purulent discharge and much free pus in the urine. In fact, at the time of the first consultation, the discharge was as free as one would expect to encounter in the acute suppurative stage of the disease. Besides this, he had gonorrhœal rheumatism, which had centered in the right knee. He had tried internal remedies together with anterior and deep injections, all to no purpose. I examined his urethra carefully. There was no stricture and only moderate tenderness. There was nothing, indeed, to be discovered in the condition of the urethra to account for the excessive discharge. Rectal examination showed the left vesicle to be very much distended, it being about the size of a hen's egg. The peri-vesicular tissues were indurated and inflamed, and the entire region was quite sensitive, a little pressure giving rise to much pain. On making such pressure, considerable fluctuation could be detected, and upwards of a drachm of purulent vesicular fluid containing many lifeless spermatozoa dripped from the meatus as the result. This consultation took place in June, 1892. My opinion at the time was that extirpation of the purulent vesicle would probably be required in order to effect a cure, as the case seemed most aggravated. Still, I decided to make a trial of stripping the vesicle. At the end of a week the case reported again for examination. The vesicle at that time was not as tense as be-

fore, and no disagreeable reaction had followed the first treatment. Feeling encouraged by these results, I sent the patient home with instructions to his medical attendant prescribing a continuance of the treatment. Early in September the patient returned and reported that he was no better. On examination the condition of the vesicle was found to be exactly as when first examined. On stripping the sac a great quantity of the purulent fluid was discharged. The patient told me that his regular attendant had never succeeded in squeezing out anything as the result of his manipulations. The consent of the medical gentleman in charge was then readily given me to continue the treatment myself. After this the patient reported regularly once in a week to ten days. The intervals between treatment were a little too long, but were as frequent as the patient could arrange. Under this systematic treatment progressive improvement ensued. In a little over two month's time the discharge from the urethra ceased, and the urine became clear. The material pressed out from the vesicle lost its purulent character and became viscid and somewhat gelatinous. The vesicular tenderness and the peri-vesicular induration also gradually disappeared. The vesicle, however, still remained distended, with its muscular walls flabby. On this account it seemed very probable that a relapse might occur should treatment be suspended. Accordingly, treatment was continued for about six months longer, although during this latter interval the visits did not average as frequent as at first, oftentimes the patient being seen but twice, and on one occasion but once during a month. At the end of this time the pouchy condition of the vesicle had disappeared, and the organ was able to empty itself as the result of seminal emissions. Since suspending treatment this case has reported occasionally in order to be assured that everything is all right. The vesicle is now performing its functions perfectly. It is normal to the feel, and nothing can be squeezed out of it. There has been no return of the urethral discharge, and the urine is perfectly clear.

III.—Thirty-five years of age, had never for any considerable interval since his first gonorrhœa, about six years ago, been free from a urethral discharge. Since his first gonorrhœa he reported having had numerous fresh attacks of the disease. As he had, apparently, been quite conservative in his sexual relations, it seemed probable that a number of these subsequent fresh attacks were simply exacerbations of the existing pathological condition. Latterly, also, added to his former com-

plaints, signs of sexual weakness had appeared. Before seeing me, both in this country and abroad he had consulted a number of eminent authorities, without any apparent benefit. The urine in this case showed a number of urethral shreds and some free pus. Nothing in the urethra was found to account for these symptoms. Sounds, anterior and deep injections, and in fact all the ordinary urethral methods had been tried without avail.

Both vesicles were found tender and somewhat distended. They were not, however, indurated, and their walls were not thickened. Considerable material appeared in the urine as the result of vesicular stripping, but it contained comparatively little pus. This case had the appearance of being a very favorable one for the treatment, and so it proved. Great relief was experienced after the first few strippings. The discharge disappeared and the urine became clear. The patient being thoroughly satisfied with his condition, soon became irregular in attendance, and then stopped further treatment before I was satisfied that the vesicles were wholly well.

As, however, the condition of the vesicles was not bad to start with, the limited treatment they received may have been sufficient to guard against relapse.

IV.—Thirty years old, consulted me for a urethral discharge which had been so profuse for the preceding six months as to saturate several clothes daily. For over a year before the present profuse discharge commenced, there had been more or less gleet, which had become quite troublesome after alcoholic excess. There was an early history of several gonorrhœas which had, apparently, occasioned only temporary inconvenience. The peculiarity of the present muco-purulent discharge was that, although very profuse, it was not accompanied by any urethral pain or vesical disturbance; in fact, the patient stated that he felt perfectly well in every way, the presence of the discharge being his only discomfort. There was considerable free pus in both the first and second flow of urine. Numerous anterior injections had been tried, many of which would hold in check the anterior discharge so long as employed, but as soon as discontinued the discharge would reappear. On commencing to treat this patient I tried deep urethral instillations of nitrate of silver. The discharge and most of the free pus in the urine would disappear for about twenty-four hours after each of these treatments, at the end of which time there would be a sudden relapse to former conditions.



Examination of the urethra showed an absence of lesions sufficient to account for the discharge. Attention was then called to the vesicles, although, as has been stated, there were no subjective symptoms pointing to those organs. The left vesicle was found to be much distended and rather tender. There was, however, but little peri-vesicular infiltration. A large amount of purulent vesicular fluid was squeezed out. This case was treated continuously by stripping the vesicle once in five to seven days for six weeks. There was then marked improvement in the volume of the discharge and also in the condition of the vesicle. At this time, however, the vesicle began to become tender to the touch and the strippings, which had latterly caused no discomfort, became somewhat painful. The material squeezed out, which had lost its purulent character, began again to show free pus. In fact, I found that my treatment had been a little too vigorous. After seeing him a few more times and stripping gently, as the vesicle still remained tender, though not much distended, the patient was sent off, and the treatment discontinued for the time being. He went away on a three months' trip. At the end of that time he reported for examination. He stated that he was well and had been wholly free from all discharge for the last two months, ever since, in fact, the soreness, occasioned by the strippings, had disappeared. Latterly he had been drinking and knocking about with women, no disagreeable after-effects resulting. Rectal examination showed the vesicles to be normal.

In this case the local treatment, although efficacious, had been a little too severe.

V.—Twenty-seven years old, came complaining of a urethral discharge associated with frequent and painful urination. At the end of each urinary act it was customary for a drop or two of blood to appear at the meatus. He also suffered much pain on the occurrence of a seminal emission. These disagreeable symptoms had persisted for two years as the result of a gonorrhoea. In the meantime the patient had been treated at the hands of numerous eminent medical men without relief. His meatus had been cut, large sounds passed, deep and anterior injections used, and topical applications through the endoscope applied, all with the result of aggravating rather than improving the existing state of affairs. Endoscopic examination did show a beefy-looking, granular spot in the deep urethra. Rectal feel showed both vesicles to be tender, distended and inflamed. Much material, associated with pus and blood, was

squeezed from them. It was thought best to leave the granular spot in the deep urethra alone, and to treat simply the vesicles by the usual method, once in every five to seven days. During the first six weeks of treatment, though the vesicular feel was constantly improving, the patient, made sceptical perhaps by his former experiences, did not admit that he was any better, aside from the fact that painful sensations at the time of seminal emissions had disappeared. Shortly after this time the discharge, the blood and the frequent painful urinations all disappeared. Then the patient became enthusiastic, and wanted to call himself cured. Treatment was continued, however, for some time, until the condition of the vesicles became quite satisfactory to the feel. Since the discharge stopped, now six months ago, the patient has considered himself perfectly well, and he has been well as far as his urinary apparatus is concerned. It has been difficult in this case to impress on the patient the importance of having the vesiculitis entirely cured before abandoning treatment. On this account there may be some future trouble in store for him.

VI.—Fifty-seven years old, came with a slight, relapsing urethral discharge together with numerous shreds and some free pus from the deep urethra. He has had this trouble continuously for six years. In early life he had had gonorrhœa a number of times. About six years ago, as the result of excessive sexual intercourse, a slight discharge appeared. The electrolysis craze was then in full swing in this country, and the doctor consulted at that time diagnosed a stricture, and advocated its cure by electricity. This agent was applied twice with disastrous results. The patient was then, for the first, seen by Dr. Keyes and myself. He remained under our treatment for some time. He was very much relieved of his distressing symptoms due to the electricity, but not cured. He then sought advice abroad, without benefit. He refused perineal drainage. In the Fall of 1893, meeting the patient and learning that he still suffered from his old complaint, I requested him to call for further examination. On making this examination chronic suppuration was discovered in connection with both seminal vesicles. These sacs were also enlarged and their walls much thickened. Besides this, marked hypertrophy of the prostate had taken place during the six years since I had examined him. The deep urethra, though but moderately strictured, seemed inelastic and unyielding. Within the last few years his sexual power had greatly diminished. Although

this case seemed most unpromising, a course of vesicular stripplings were given. No benefit, however, being experienced except, possibly, in the way of increasing slightly the sexual capacity, treatment was abandoned. Formerly, before the vesicles had been examined, my opinion had been that a perineal section and drainage would have cured this patient. I now think that such an operation would have proved a disappointment to all concerned.

VII.—Thirty-five years of age, had a gonorrhœa in 1889, and had not been well since. This statement was made early in September, 1893. During 1890 and 1891 he suffered much from a relapsing discharge associated sometimes with blood. At this period also his urinations were frequent and urgent. In the urine, besides free pus, there were large clumpy shreds from the deep urethra, with oftentimes some adhering blood clots. Numerous urethral treatments were tried without benefit, and in 1892 he submitted to perineal section and drainage. From this operation he received considerable benefit. The bloody element disappeared and only a slight gleet discharge remained. His urinations were, however, still quite frequent and urgent. He had pain in the perineum, and he experienced little satisfaction or relief from sexual intercourse. In September, 1893, the seminal vesicles having been found to be distended and inflamed, stripping was tried, and much firm gelatinous material pressed out. This course was continued at frequent intervals for two months, and then more infrequently for three months longer. Under this treatment the discharge soon wholly disappeared together with the perineal pain, the urinations became normal as regards frequency and urgency, and his sexual sensations were again natural. In all probability in this instance much discomfort together with the perineal section might have been avoided had the value of vesicular stripplings been known two years or more before. Still there is much satisfaction in making a final cure in such a case.

*(To be continued.)*

## A CASE OF XANTHOMA MULTIPLEX.

BY

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**S.** R., a married woman, æt. 50, seamstress, presented herself for treatment at the skin clinic of the Philadelphia Polyclinic on June 13th, 1893. Four years ago she had an attack of grippe, and about one month later this was followed by jaundice of the general surface of the body. This condition exists at the present time. She has suffered from attacks of rheumatism and three years ago contracted syphilis.

The present condition is as follows: she is a poorly nourished woman of spare build, measuring five feet and one inch in height, and weighing 125 pounds. She suffers occasionally from headache, which has been considerably relieved since wearing her hair cut short. She states that she is quite drowsy during the day and that when unemployed falls asleep very readily.

Her general health is fair, appetite good, tongue badly coated, bowels regular, although at times being clay-colored and at others more dark and always of a diarrhœic nature. Bodily temperature usually normal, pulse sixty-four.

She is now the color of a mulatto, and both conjunctivæ and the mucous membranes of her mouth are deeply jaundiced. The same condition also involves the whole body surface but is not so deep upon the legs and feet.

On palpation there is felt in the neighborhood of the normal position of the gall bladder an exceedingly hard mass extending obliquely for about three-quarters of an inch from the borders of the ribs. Liver dullness begins in the sixth interspace, in the recumbent posture anteriorly and on the same level posteriorly.

There is no ascites. On palpation of the liver nodular masses can be felt. Examination of the urine reveals the presence of bile pigment; reaction neutral, specific gravity 1,010; albumen, but no sugar.

The blood contains 4,630,000 red corpuscles to the cm., with no increase in the white corpuscles. Hæmoglobin estimate, 60 per cent.

In February, 1893, xanthomatous lesions appeared at the inner canthus of both eyes, on the upper eyelids (xanthoma



palpebrarum), consisting of slightly elevated lemon-yellow plates about the size of a pea. The mucous membranes of the



FIG. 1.

cornea and conjunctiva and the oral cavity are free from any similar growths. The palmar surfaces of both hands show very numerous lesions of a like character, which are distributed

along the natural furrows of the skin of the hands and fingers. The internal surface of the thumb shows the same condition.

The knuckles of each finger of both hands and also the dorsal surface of the thumb are studded with numbers of similar lesions, which vary in size from a millet seed to that of a large pea (*xanthoma-tuberosum* or *tuberculatum*) and are velvety to the touch (Fig. 1). The lesions on the palms vary from lemon-yellow to rose in color, those on the dorsal surface of the fingers and thumbs being purely lemon-yellow. The growths do not coalesce, and when opened do not discharge any contents, and according to the patient's statement, are very itchy on the fingers and interfere with her occupation. She does not complain of any marked inconvenience in the other localities where the lesions exist, with the exception of a slight pruritic sensation. At the angle of the jaw, and along the inner border of the sternocleidomastoid muscle on the right side and below the right ear posteriorly similar growths are present, showing variations in color from yellowish to pink.

Lesions of a xanthomatous character are also visible posteriorly, distributed along the inner and upper contour of both scapulæ and showing great similarity with the corresponding shoulder blade in their arrangement (Fig. 2). A group of similar nodules exists on the internal surface of the right upper arm near the axilla, and also on the left upper arm posteriorly, although not so well marked as on the right side. On the extensor surfaces of both elbow joints there are situated numerous nodules of a like character, arranged in a manner resembling the eruption of herpes, and showing decided symmetry in distribution on both elbows.

On the inner surface of the right forearm below the internal condyles of the humerus, a group of the same lesions are noticeable. On the dorsal surface of the feet there are situated, at the metatarso-phalangeal articulation of the great toe, between it and the second, between the third and fourth, and between the fourth and fifth toes, lesions arranged in *striæ* (*xanthoma lineare vel striatum*) and of a pale, yellow color. Telangiectases are nowhere visible. Careful questioning as to the patient's family history failed to elicit the occurrence of a similar eruption in any other member on either side.

After being under observation for five months the eruption has not undergone any change, new lesions have not appeared nor have any disappeared, with the exception of those removed by the knife.



FIG 2.

In explanation it is probably well to add that the disease under consideration, which is also known as xanthelasma; vitiligoidea, molluscum cholestérique (Bazin); fibroma lipomatodes (Virchow), and defined by authors as a fibro-fatty neoplasm forming yellow plates or tubercles in the corium, is regarded as an unusual affection. The form known as xanthoma palpebrarum and occurring, as the name denotes, on the inner canthus of the left upper eyelid, and usually existing in plates, is encountered in the majority of cases.

Pye-Smith (Guy's Hospital reports, 1877) regards the disease as "consisting anatomically in a chronic hyperplasia of the deeper layers of the cutis, in which the papillæ and epidermis, on the one hand, and the subcutaneous connective tissue on the other, are only secondarily involved. The process may run in two directions. When it follows what may be called the inflammatory type, the minute, round, inflammation cells or young leucocytes never form true tissue elements, molecular fatty degeneration rapidly overtaking them, and leading to their ultimate disappearance in a detritus of oil drops, calcareous masses and cholesterine crystals."

According to Hallopeau (*Annal. de Derm. et Syph.*, 1893; iv., 935) the growths occurring in xanthoma are benign neoplasms of embryonic origin, and he believes, with Touton, that they owe their origin to the generative embryonic fat cells which persist in the tissues and proliferate.

Hallopeau thinks it probable that the jaundice, which often coëxists with the disease, may be caused by the presence of these cells in the bile ducts, and that the glycosuria which is present in those rare cases, known as xanthoma diabeticorum, is perhaps caused by these cells being situated in the pancreas.

The etiology of xanthoma is still obscure, although numerous theories have been advanced. Most authors regard the disease as a connective tissue new growth with fatty degeneration.



RAYNAUD'S DISEASE—WITH REPORT OF THREE CASES.

BY

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THIS remarkable and interesting condition which bears the name of Raynaud was first described by him in 1862 under the name of "Local Asphyxia and Symmetrical Gangrene of the Extremities," and again with a report of several cases in the Paris Archives of Medicine for 1874.

Since then other observers have reported similar cases. In all instances the attention is first attracted by the bluish color of the extremities. This will oftentimes, without any apparent cause, change to a violaceous, almost black color, which persists some hours and the parts then resume their ordinary hue.

These attacks, which first called Raynaud's attention to the condition, received from him the name of local asphyxia.

The thumbs are not affected and the color never becomes normal, especially upon the left hand.

During severe attacks of local asphyxia an indistinctness of vision was observed and an ophthalmoscopic examination made at the time showed contractions of portions of the arteries in the fundus which would take place under the eye of the observer, persist for a while and then disappear to form in another part of the artery. The uncontracted portion of the artery remained dilated to its full extent, and a strong pulsation could be seen in the veins. During the intervals of cyanosis the vessels were wider and the pulsation in the veins persisted. The right eye was less affected than the left.

Raynaud further experimented by cutting the end of the cervical branch of the sympathetic, and applied an electric current to the distal cut end, producing the characteristic vessel contraction, which relaxed on stopping the current. He therefore suggested that the cause of the disease might be found in some abnormal excitement of the vaso-motor nerves.

Since it has been demonstrated that a spasmodic contraction of the arteries of the eye takes place during an attack, it is but reasonable to suppose that the same condition affects all the arteries through the body. This contraction will not interfere with the perviousness of the larger arteries, but will only make itself noticeable when it comes to affect the terminal filaments,

where a slight amount of contraction will be enough to shut off the calibre almost completely.

When the arterial walls are thickened by the infiltration of syphilis or the connective tissue growths accompanying contracted kidney, it will be easy to see how an amount of vaso-motor spasm which would be scarcely noticed in a healthy artery can entirely close the already contracted vessel.

Jacoby <sup>1</sup> and Sturmdorf <sup>2</sup> have raised the question as to whether a number of cases, which have been reported as Raynaud's disease, were not in reality due to other conditions aside from a pure vaso-motor spasm and have suggested that cases resembling two of the following were not Raynaud's disease, but the results of an obliteration of the artery from organic disease of the vessel walls.

It seems to me probable that if the element of vaso-motor spasm had been entirely absent in cases II. and III., reported below, the circulation would have been maintained constantly at the same plane or a gradual lessening would have taken place until gangrene had supervened and the characteristic periodical attacks of local syncope would not have been observed.

It would not seem illogical to consider that the conditions found in these cases were due to a combination of circumstances.

One peculiarity of the disease is that all the extremities of the body, hands, feet, nose and ears may be affected, but not of necessity in an equal degree. The toes may show but slight marks of an abnormal circulation or may be severely affected. Any partial occlusion of the terminal arterioles will result in diminishing the *vis a tergo*, the blood flows slowly through the capillaries, which soon become dilated. This dilatation in itself is a favoring element in bringing about an increase in the condition of passive congestion which is a feature of the various stages of the disease.

The retarded circulation affects the nutrition of the tissues, more especially the finger ends and appendages. The nails in some cases become dry, brittle and split. On examination they are found flattened and eroded. The pulp of the finger tips is absorbed, and the epithelium scales off. The tactile sensibility may be diminished. The temperature of the fingers is sub-normal, on account of the enfeebled circulation, and the patients always complain of coldness, which is also very evident to the observer. The color of the extreme ends of the fingers

<sup>1</sup> N. Y. Med. Journal, February, 1891.

<sup>2</sup> Med. Record, August 1, 1891.

may be white and pale, and any exposure to cold will temporarily increase the pallor by still further lessening the supply of blood.

Beyond the borders of the zone of local anæmia the tissues are bluish or livid in color, from the capillary venous stagnation. In other cases the fingers are not pallid, but the bluish color extends to their extremities.

Pain is intense in some cases, in others it is absent.

While the arterioles retain their perviousness the disease progresses but very slowly. But in course of time a complete obliteration of the vessels may take place, shutting off all the supply of arterial blood, and the tissues heretofore insufficiently nourished, now deprived of their pabulum, rapidly necrose. The necrosis is limited to the soft parts, and does not include the bone. As in ordinary cases of gangrene, a line of demarcation forms and the new granulations push off the necrotic mass. The necrosis may be limited to the tip of a single finger. It may involve all the fingers of one hand, or both hands and toes may be affected in a greater or less degree.

With regard to the questions of prognosis and treatment it may be convenient to consider the disease according to its etiology.

There are three conditions which will produce a complete or partial obliteration of the calibre of the vessels :

Class I.—Spasmodic contraction of the muscular fibres of the vessel walls due to vaso-motor influences.

A. B., aged 40, occupation, farmer, residence, central part of New York State, came to my clinic at the Long Island College Hospital with the following history: Several years ago he had begun to suffer greatly with cold fingers in the Winter. The two terminal phalanges would become white, and remain so for hours. The remainder of the hand was livid. The duration of the attacks increased so that finally the fingers would remain white, livid, and cold all Winter and then finally both Winter and Summer. He was liable to attacks of an increase and deepening of the livid color so that it would become almost black, remain so for some hours, and then give place to the ordinary appearance. The nails also underwent the usual changes. Two years ago, half the soft parts of the second terminal phalanx of the left hand became gangrenous and sloughed off. This patient had never had syphilis, and was a strong, vigorous, robust man. His urine was normal. This case was seen by Drs.

Sherwell, Wight and Winfield, who all concurred in the diagnosis.

This was undoubtedly a case of pure vaso-motor spasm, such as Raynaud described in his original series of cases.

The treatment which he applied was the descending current with a view of lessening the excito-motor power. The positive pole was placed on the spinous process of the seventh cervical vertebra and the negative in the lumbar region.

The result of this treatment was very successful in all his cases. An improvement was observed immediately after the first application, and as the treatment was continued the patients grew better until the color and temperature of the hands became normal.

Class II.—Arterio-fibro sclerosis accompanying chronic interstitial nephritis.

Mrs. R., age 35, and mother of six children, five living and healthy. No history of syphilis. Came under my care in March, 1891. She had suffered for a number of years from the effects of a chronic interstitial nephritis, and once or twice a year would have an attack of fever, gastric disturbance, urine loaded with albumen and urates in large quantities. During the intervals urine was profuse in quantity, of low specific gravity and with occasionally a trace of albumen. She had also the characteristic increase of vascular tension. In November, 1892, as she was recovering from such an attack, she began to complain of intense pain in the fingers of both hands. They had been cold and white and occasionally blue for a long time before. The fingers of the left hand became livid, then black and finally all the terminal and second phalanges became necrotic and sloughed. After a distinct line of demarcation had formed, with the assistance of my friends Drs. Shaw and Baldwin I amputated the fingers and secured a good result. The patient is living to-day, and the fingers of the right hand are cold, and white and bluish, which becomes much darker at times. In this case I believe the shutting off of the circulation to be due to the general change in the walls of the arteries accompanying the chronic interstitial nephritis with very probably a superadded element of vaso-motor spasm.

In such a case as this nitroglycerine would probably have a beneficial effect from its action in lessening vascular tension and relieving vaso-motor spasm and thus assisting to maintain the perviousness of the arterioles.

Class III.—Endarteritis of syphilis.



J. R., England, age 36; came to my clinic at Long Island College Hospital Dispensary, and stated that fifteen years ago he had acquired syphilis but that after three months treatment had never shown any manifestations of the disease.

For some years past his fingers and toes have been cold and white and the hands have been livid. He has observed that the blue color of the hands would become markedly increased at times. This would persist for a short time until the usual bluish color returned. His finger nails and pulps and the skin about them show marked evidences of impaired nutrition and the toes as well. The temperature of the left hand is noticeably lower than the right. An examination of the chest fails to show either aneurism or valvular disease of the heart which could produce an embolus. His urine is normal. I presented this patient at a meeting of the Brooklyn Dermatological Society as a very mild form of Raynaud's disease due to a partial obliteration of the vessels from endarteritis, together with a superadded element of vaso-motor spasm. The gentlemen present all agreed in the diagnosis.

In cases of this class I believe the prognosis is more favorable than in the others. I placed the patient on anti-syphilitic treatment. Under the influence of small doses of bichloride and increasing doses of iodide of potash up to the limit of 60 grains three times a day continued for some weeks, his condition has improved; the color of his hands is better, they are not as cold and he has not had any attacks of local asphyxia of late.

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PERIURETHRAL PHLEGMON NEAR THE FRÆNUM (PARA-FRÆNITIS PENIS).

BY

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**P**ERIURETHRAL Phlegmon is a localized cellular inflammation occurring along the course of the urethra in the surrounding tissue, and manifesting itself as a small abscess upon the lower surface of the organ. These may occur at any point along its course, but as by far the greater number of them are found in the fossa behind the corona of the glans and beside the frænum, I shall consider this class only in my paper, under the name Parafrænitis.

*Varieties.*—There are several varieties of parafrænitis, namely :

(1) Simple, when it is limited to one infection. This may be single, occurring on one side of the frænum ; or double, when on both sides.

(2) Relapsing, when it follows the course of a urethritis, developing with its exacerbations and not appearing during its period of inactivity.

(3) Recurrent, when it accompanies two or more successive attacks occurring independently of one another.

*Etiology.*—The primary cause of periurethral abscesses in this region is a constricted meatus which brings a constant strain during micturition on the fossa navicularis and its surrounding tissues. When in these cases an acute urethritis develops it is apt to center in the fossa and, on account of the extra strain and irritation brought on this region, to spread to its surrounding tissues. The way that it extends to the point where the localized inflammation occurs is probably along the ducts of the glands or follicles of Littre ; but unless a periglandular or perifollicular inflammation is set up it does not seem probable that the characteristic abscess will develop. It is possible that the infection may also be absorbed through an erosion in the urethra and produce a similar lesion. The exciting cause which usually brings on this complication during an attack of urethritis in those so predisposed is an excess in the indulgence of alcoholics or venery, singly or combined. There is no fixed time for the development of this complication, but it usually takes place at the end of the first or second week. The favorite seat is the right side.

(1) *Simple Parafrænitis* occurs and is limited to one infection. It appears as an area of tenderness on one side of the frænum, which on examination seems elevated above the level of the surrounding tissue, and to have a shiny, glistening appearance. This may disappear in a few days or it may continue to increase in size and sensitiveness until it becomes a large inflamed, reddened nodule varying in size from a small pea to a cherry, and closely resembling a furuncle in its outward appearance. It is in this stage exquisitely tender to the touch and undergoing rapid degeneration. A white point then shows itself over the middle of the lesion, announcing the presence of pus. It then breaks, unless opened, discharges, and leaves a suppurating base ; a fistulous tract is thus frequently left opening externally, or internally when the abscess breaks into

the urethra—a rare occurrence. Cases are also not infrequently noticed where the abscess has penetrated both internally and externally, leaving a complete fistula.

(2) *Relapsing Parafrænititis*.—In these cases the phlegmon follows the course of the disease, as we have already mentioned, being governed in severity by its exacerbations. An attack of urethritis accompanied by a phlegmon in this locality may become chronic and remain in this condition for several weeks, during which period the abscess has broken or been opened, discharged its contents and healed. A sudden debauch or excessive venery may then bring on a return of the acute urethral discharge, followed in a few days by the appearance of the abscess *de novo* in exactly the same locality, and following the same course. This may occur several times during an attack of urethritis, especially if it extends over a long period.

(3) *Recurrent Parafrænititis* is a condition where the abscess is apt to occur with each fresh attack of urethritis, even when the previous one has been completely cured, and several months or years have elapsed between them.

I will here give the clinical histories of three cases of this trouble, illustrating its different forms:

*Case I. Simple Parafrænititis*.—R. W., a broker, age 25, presented himself with an acute attack of urethritis. First infection: the discharge was profuse, and of the characteristic color. Ordered diluents and astringent injections. Two weeks later a gonorrhœal cystitis developed. The anterior injections were then discontinued, and the patient was put on an anti-cystitis mixture. As he was overworked and on his feet most of the day his cystitis continued for some time, and he became very much weakened and “below par.” One month after the infection he noticed an inflamed and painful swelling on the right side of the frænum about the size of a split pea, which rapidly grew worse, and at the end of five days burst and discharged its contents. The abscess-sac was washed out and touched with a saturated solution of arg. nit., and afterward dressed t. i. d., with A. B. C. powder. One week later it was entirely healed.

*Case II. Relapsing Parafrænititis*.—J. S., a traveling man, age 21, contracted an acute urethritis. Fifth infection: discharge profuse, etc. None of his preceding attacks had been accompanied by cellular inflammations along the canal. Two weeks after the onset, during which time the patient had continued drinking and leading a careless life, the characteristic abscess appeared on the right side of the frænum. In a few days this

burst and discharged its contents. The abscess-sac was cauterized and treated by applications of aromatic wine. The urethral discharge diminished to a "goutte militaire," and the abscess was cured. The patient was well, with the exception of a little moisture mornings, for a month, during which time he took salt water baths daily, and enjoyed various kinds of healthy exercise. He then returned to the city, where he indulged in free living, accompanied by excessive venery and the use of alcoholics. His discharge soon began to increase, slowly at first, but after a week or ten days it had become quite profuse again, when the abscess once more appeared and followed a similar course. The abscess having healed, and the discharge having once again become gleet, he discontinued his treatment, and again indulged with the same result, *i. e.*, a return of the discharge and phlegmon. After this third attack he contracted a fourth, which ran the same course, making in all four relapses during a period of four to five months. In attacks of urethritis contracted since this no relapse or recurrence of this complication has occurred.

*Case III. Recurrent Parafrænititis.*—J. B., a student, age 20, suffering from urethritis. Third infection: noticed an area of tenderness on the right side of the frænum, slightly elevated, having a glistening tense appearance, which was very sensitive to the touch. This slowly disappeared, forming no abscess, and the urethritis was cured. Five months later the patient again developed a urethritis, followed by a similar inflammatory condition, which developed into an abscess, broke down, suppurated, burst, discharged and healed. The urethral discharge also ceased. Two years later, during which time the patient had been entirely well, he again developed a urethritis, and an abscess occurred in the same locality, which was poulticed, opened, and healed, leaving a fistula into the urethra through which a drop of urine escaped during micturition. Shortly after this he developed a slight catarrhal inflammation in this fistulous tract, the urethra remaining unaffected. This was accompanied, later, by an attack of monarticular gonorrhœal rheumatism, which disappeared shortly after the discharge from the fistulous tract was cured. One year later the patient again developed a catarrhal inflammation in this fistula, to which he did not pay much attention, as it was of very little inconvenience. The inflammation, however, traveled along this fistulous tract, and the mucous membrane of the urethra became infected, giving rise to quite a severe urethral discharge, lasting



for two months. This was cured by urethral injections, and was followed by a closing up of the fistula, which was then of quite long standing.

*Treatment.*—When the localized inflammation first occurs dress it with a cotton pledget soaked in bichloride solution, 1 in 4,000, or lotio Nigra. Later, if it seems to be going on to supuration, apply small poultices. When the abscess has developed open it and cauterize the base with the silver stick, nitric acid, or a saturated solution of nitrate of silver. Nitrate of silver is the best caustic to use in these cases, as its action is more superficial than that of any other.

After the abscess has been opened or burst a suppurating abscess cavity remains, which continues to discharge for some time, unless it is touched occasionally, as, every second day, with a 1 to 8 solution of nitrate of silver, and dressed with an astringent or antiseptic solution or powder, *e. g.*, a weak solution of bichloride, lotio nigra, Thiersch's solution, aromatic wine, A. B. C. powder (composed of equal parts of boric acid, subnitrate of bismuth and calomel), iodoform, etc. Of course, the urethritis should be treated at the same time internally by diluents, or anti-bleorrhagics, and externally by mild astringent solutions.

79 West Fifty-fourth Street, New York.

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#### A PERINEAL TUBE HOLDER

F. TILDEN BROWN, M.D.,

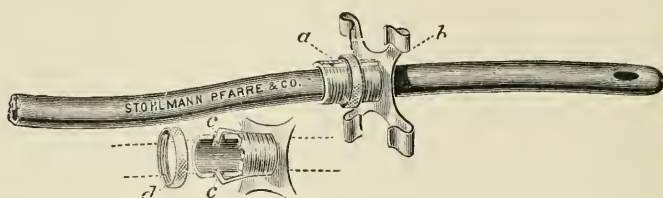
New York.

FOR long-continued drainage of the bladder by means of the perineal tube some device which will permit of ready removal or adjustment of the tube is absolutely necessary. Even in such cases as need to wear the tube but a short time—a week or two—this method of securing it is to be preferred to the usual way, that of passing a suture through one or both lips of the wound and the tube.

The disadvantage of permanently fixing the tube by suture is sometimes noted after an operation, but to readjust the tube or to remove it for cleansing necessitates cutting the suture and then disturbing the patient not a little by the introduction of another.

The patient is commonly in the lithotomy position when the tube is first sutured in place, and it is ordinarily aimed at to have the vesical extremity of the tube near the outlet, so as to drain well. When the legs are extended the distance from the bladder to the perineum has been increased and the eye, or extremity, of the tube may now lie in the prostatic urethra; if it does the drainage may be imperfect, and irritation of the bladder with increasing tenesmus may be expected to occur and continue until the tube has been readjusted and passed well within the internal sphincter.

To obviate these annoyances the accompanying holder was devised and used with great comfort to the patient and convenience to his attendants. The holder is of light silver



construction except the two steel springs; these have sharp teeth which hold but do not puncture the rubber tube. The springs release the tube by turning the screw collar. The cylinder has a calibre of thirty-five, French, and the spring teeth have play sufficient to hold any tube of from thirty-five to twenty-two, French. Tapes or narrow bandages slipped under the horns of the plate, then brought up radiating and secured to a waistband in front and behind hold the apparatus in place. A continuous tape for each side is preferable, as it permits the plate to remain stationary while they play through or under the horns, as the changed position of the body in sitting or reclining may necessitate. The plate is narrow enough not to meet the opposing surfaces of the thighs. Nor does it interfere with defecation. I have the patient wear a fresh pad of iodoform gauze between the perineal opening and the plate after each movement of the bowels.

## Society Transactions.

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### THE NEW YORK DERMATOLOGICAL SOCIETY.

#### 231ST REGULAR MEETING.

DR. C. W. ALLEN, *President, in the Chair.*

#### A Case of Lupus.—Presented by DR. J. A. FORDYCE.

The patient was a boy, aged 3 years, with a lesion on the ball of the thumb of the left hand. It consisted of a small, warty, indurated patch which first appeared about two years ago; since then there has only been a slight increase in its size. Dr. Fordyce said it was undoubtedly a case of lupus, and was interesting chiefly on account of the early age of the child.

DRS. JACKSON and SHERWELL agreed with the diagnosis of lupus vulgaris or tuberculosis of the skin.

#### Case for Diagnosis.—By DR. ELLIOT.

The patient was a female, aged 40, with a distinct history of syphilitic infection several years ago. Five years ago an elephantoid condition developed on both hands and feet, with a markedly verrucous condition of the palms, soles and toes. The question arose whether this verrucous condition depended on syphilis or not?

DR. JACKSON regarded the lesions as syphilitic or at least as of a syphilitic basis. Similar cases which he had seen in Randall's Island had all been improved rapidly under the use of mercurial ointment.

DRS. CUTLER and SHERWELL considered the lesions as syphilitic, the latter pointing to the condition of the nails as characteristic of syphilis.

DR. FOX said the case was similar to others he had seen in which an eczema had developed on a syphilitic base. This papillomatous condition, which might occur in the dry or in the moist papillary form, was not infrequently met with, especially on the hand and forearm. The syphilitic origin was betrayed by the scalloped outline of the patches.

DR. BROXSON said it was an inadequate diagnosis to pronounce this disease simply as syphilis. The feet presented an elephantoid condition due to a complexity of causes. An eczematous element was evident in the case, which, like any long-continued irritation, might possibly have helped to evoke the syphilitic infiltration and the deranged nutrition of the skin resulting from it. The syphilitic infiltration, on the other hand, by interfering with the proper nutrition of the skin, would tend to render the soil more favorable for the development of the eczema. Thus one condition egged on the other.

DRS. FORDYCE, LUSTGARTEN, MORROW and KLOTZ did not consider the lesions as syphilitic.

DR. LUSTGARTEN had never seen a case exactly similar; he would not make a diagnosis. The case resembled lupus-like changes brought about by a chronic dermatitis of the upper layer of the skin.

DR. MORROW said, as the woman stated, she was very much exposed during the blizzard some years ago, and he was rather inclined to regard

these lesions as the result of dystrophic changes due to frost-bite or something of that nature. The elephantoid condition would develop as the result of long-continued inflammation and stasis.

DR. KLOTZ called attention to the atrophic condition of the cutis and the cachetic appearance of the patient.

DR. ALEXANDER said he had never seen a case exactly similar, and he would not make a diagnosis. One patch on the left arm, in appearance and outline, closely resembled a squamous syphilide.

DR. ELLIOT said he presented this patient before the Society two years ago. She gives an undoubted history of syphilis. The consensus of opinion at that time was that the papillomatous condition of the skin was a secondary process and not of syphilitic origin. In some particulars this case resembles three cases of Darier's disease that have come under his observation, and he presented the patient on account of this.

#### **A Case of Urticaria Pigmentosa.—Presented by DR. BRONSON.**

The patient was a boy, two and one-half years old, who had had the disease since he was five months old. According to the statements of the mother it had been very uniform in its character, the seasons having very little influence upon the eruption. It does not appear to have interfered at all with the child's general nutrition.

The case was regarded as a characteristic and typical one of urticaria pigmentosa by the members present.

DR. MORROW called attention to the striking resemblance of Dr. Bronson's case to one reported by himself several years ago, the first one observed in this country. He stated that in most of the cases he had seen since the factitious urticaria was a more pronounced symptom than it was in the case presented.

DR. FOX said it would be interesting to learn how this case and others previously presented to the Society finally resulted, whether they got well or not. He had lost sight of two cases which he had had under his own observation.

DR. MORROW had kept his case under observation for three or four years. The eruption remained practically unchanged by treatment. There was slow involution of the old lesions and a constant formation of new ones.

DR. ALLEN said that the fact that we see adults with the same disease, which almost invariably develops in childhood, would tend to prove that they do not all recover.

DR. FOX said that in one case presented to the Society, an adult, the disease did not develop in childhood. He has had one case under his care which improved considerably; the disease, however, had not entirely disappeared when he lost sight of the patient.

DR. LUSTGARTEN believed that the case of urticaria pigmentosa in a man 21 years of age, presented by him last year, was the oldest case on record. All the other cases reported dated from early childhood. He, too, had lost sight of the patient. In most of the cases reported the patients recovered before they reached puberty. As regards treatment, there is none which can affect a cure. The etiology of the disease is decidedly different from that of common urticaria. He advised the use of pilocarpine, beginning with one-sixth grain doses and gradually increasing it until moderate perspiration is produced.



DR. ELLIOT referred to a case of urticaria pigmentosa in an adult, 32 years of age, that he had presented before the Society some years ago. It was a typical case and the man had no traces of the disease before the age of 30.

DR. SHERWELL has under observation urticaria pigmentosa in a man 33 years of age. Some spots slowly disappear while fresh ones crop out. He inquired whether any gastro-intestinal disturbance, usually so pronounced a symptom in acute urticaria, was present in Dr. Bronson's case?

DR. CUTLER mentioned a case of this affection under his observation, a child 8 years of age, who had repeated attacks of urticaria until the age of two and one-half years. Since then no attack has occurred, but the pigmented spots remain unchanged.

DR. TAYLOR referred to a case of urticaria pigmentosa which he saw twenty-five years ago in a child. This disease being entirely unknown in those days, the case was pronounced by many who saw it as one of hereditary syphilis, in which the patches of a roseola had left this pigmentation. In another case that came under his observation, that of a young woman, the disease had persisted for four or five years. The whole body, particularly the buttocks, was covered with pigmented spots. There was marked gastro-intestinal disturbance. She was treated with bismuth and similar preparations, with strict attention to diet, and was finally cured. This was four years ago, and she is still perfectly well.

DR. BRONSON said the fact should not be lost sight of that chronic urticaria leaving pigmentation was not identical with urticaria pigmentosa. He had observed some years ago a case of chronic urticaria in which the skin was pigmented so that it looked like a case of vagabondism, the recurrent eruption, the long-continued scratching, etc., having produced the pigmentation. The distinctive feature of urticaria pigmentosa was the recurrence of the wheals over and over again at the same site. This finally produced hyperplasia and pigmentation. He would feel very chary of accepting a diagnosis of urticaria pigmentosa in an adult. In the case presented, no matter how much the skin was irritated, he had not been able to evoke a wheal excepting at the site of lesions already existing. As regards the use of pilocarpine, his experience with the drug in urticaria had not been satisfactory. He had employed it in the case of chronic urticaria with general pigmentation referred to above, producing diaphoresis and a certain amelioration of the itching, but the effect was only temporary, and the depression was so serious that it deterred him from using it further. He had administered it in gradually increasing doses.

DR. LUSTGARTEN said that his case of urticaria pigmentosa in an adult was a typical one. At the time the patient was presented no doubt was expressed by any of the members as to the diagnosis. As regards the use of pilocarpine in chronic urticaria, in some cases it must be pushed to enormous doses, 25 to 30 drops of fl. ext. jaborandi t. i. d. It is true that the depressions following its administration may at times be quite marked.

DR. MORROW said that in the case that had been under his care, in which the factitious element was very pronounced, it was easy to develop a wheal by any slight irritation with the point of a pencil, etc., and this could be done on the healthy skin; such factitious lesions pursued the same course as those which developed spontaneously, except that they were slower in undergoing involution. They subsequently became of a slight

yellowish brown, sometimes greenish color. This patient was treated for a long time with arsenical waters, which produced a very decided improvement in the condition of the skin as long as the treatment was continued.

DR. ALLEN also took issue with Dr. Bronson's assertion that the wheals developed only on the site of previous lesions. Drawing the finger across the skin, or sometimes the fact of merely taking off the clothing, would bring out fresh lesions, sometimes causing a giant urtica including sound skin.

DR. BRONSON replied that he had not intended to convey the impression that no new wheals ever occurred, for they certainly did. New ones appeared from time to time and old ones disappeared. But what constituted the distinctive feature of the disease was the marked tendency of the wheals to recur at the same site, and it was upon this character that the peculiarities in appearance and structure of the lesions depended.

DR. ELLIOT said he thought the most characteristic feature of urticaria pigmentosa was the fact that where the pigmentation remained you can always reproduce the wheal by irritation.

#### **Case of Mycosis Fungoides.**—Presented by DR. LUSTGARTEN.

The patient, German, male, 49 years of age, has had during the last five years a skin trouble, intensely itching, eczematous in character, consisting of round or oval, some annular infiltrated squamous patches. About one and one-half years ago a tumor developed in the right zygomatic region which has attained the size of an egg. During last Summer the eczematous affection became very pronounced, but subsided considerably under the influence of treatment, which had a marked effect on the itching. Pilocarpine was given first, afterward arsenic and local applications. In November he had an attack of urticaria "porcellanea," lasting about two weeks, which may be considered as a form of relapse. He is now given arsenic hypodermically, one-third of a grain of sodium arseniate, every other day, and, besides, forty drops of a one per cent. solution of the same preparation internally. Under this treatment the tumor has begun to decrease in size and to skin over. There is also present a small tumor-like lesion on the left upper eyelid and a few more of similar character on the scalp.

The case was regarded as a typical one by the members present.

DR. FORDYCE thought it was unusual to see only one tumor present. He mentioned a case of sarcoma which he recently saw. The primary growth developed in the nasal cavity; it became so large that it caused the eyes to bulge. The post-cervical, epitrochlear and submaxillary glands became involved. Syphilis could be excluded.

DR. BRONSON said that the application of a 50 per cent. ointment of ichthyol in a case recently under his care apparently hastened the involution of the outgrowths upon the skin.

DR. MORROW reported great alleviation of the symptoms in one case under his treatment by the oleate of bismuth. Internal remedies did not seem to have any effect.

DR. FOX did not see any proof that the reduction in size of the tumor in Dr. Lustgarten's case was due to the arsenic, from which drug he could never derive any benefit. The tumors, as he had noticed in a number of instances, sprang up and disappeared spontaneously; the patients would go from bad to worse and finally die. No remedy with which he was acquainted

seemed to influence the course of the disease in the slightest degree. Of the two cases which he presented to the Society one died, and in the other death will probably occur in the near future. He called attention to the fact that the early lesions often present an appearance of marginate eczema, especially those in the axillary or pubic regions.

DR. SHERWELL thought that Dr. Fox undervalued the effects of arsenic in dermatology. There were a number of cases of sarcoma of the skin on record in which the good effects of arsenic were quite apparent. He referred to a case of melano-sarcoma under his own care in which, under the use of arsenic, the growth disappeared and had not recurred after one year, when the patient was lost sight of, and another case of his own (*American Journal Medical Sciences*, October, 1892,) and also to cases reported by Köbner and Funk. The drug certainly seemed to influence tissue changes. The eczematous condition of the lesions as well as the other symptoms mentioned by Dr. Fox were referred to by all classical writers on this subject.

DR. CUTLER said he has much faith in the use of arsenic in this affection if the tumors are of small size. In growths as large as that presented by Dr. Lustgarten's patient he would recommend operative interference. It would probably never disappear under the use of internal remedies. Excision of the tumor, combined with the internal administration of large doses of arsenic, he thought would bring about decided improvement in the man's condition.

DR. ELLIOT was much interested to see this patient to-night, as he had treated him several years ago for almost two years. He then presented patches of an eruption all over the body which he regarded first as a peculiar form of eczema, then as dermatitis herpetiformis, without reaching a definite diagnosis. He did not think that the diagnosis of mycosis fungoides could be made when the eczematous symptoms alone existed. The patient referred to by Dr. Morrow had also been under his care for a time. He developed an ulceration in the buttock, which was removed and microscopically proved to be a typical epithelioma. In a patient of Dr. Fox's, upon whom Dr. Elliot performed a post-mortem, he also had found that the areas, where the tumors had disappeared spontaneously and had apparently left a scar, had become transformed into epithelioma.

DR. LUSTGARTEN said the chief point of interest seemed to be the treatment, which so far had not proved satisfactory. Two cases had been reported as cured, one by hypodermic injection of arsenic (Köbner), and one through an intercurrent attack of erysipelas (Bazin). In the present case, under the use of arsenic, the tumor had decreased in size and the other symptoms had been favorably influenced. If the improvement would not continue he would make injections with erysipelas toxines, as had been done by others with encouraging results in a number of cases of sarcoma. Mycosis fungoides must be ranged among the large class of sarcomatous new-growths (sarcoid tumors of Kaposi), but as a comparatively mild form.

#### A Case of Eczema Seborrhoicum.—Presented by DR. SHERWELL.

The patient was a man, aged 63 years; he came to this country from Scotland in 1858. Personal and family histories negative. The present trouble came on in August, 1893, the eruption first making its appearance at the vertex, face and the right side of the sternal region. He came under

Dr. Sherwell's care in October, 1893. The disease has been steadily growing worse. Numerous remedies have been employed with but temporary benefit, among them being resorcin, chrysarobin, salicylate of soda, etc. Internally he has been given salol, tonics, etc. Only temporary improvement has taken place. The lower right leg and the anal region have also become affected so intensely that he could not reconcile it as eczematous connection.

The case was considered as one of seborrhœal eczema by the members present (by Dr. Lustgarten as parasitic, by Dr. Robinson as seborrhœal and toxic).

DR. CUTLER thought that the eczema was complicated with lymphangitis and cellulitis, which eventually might end in a more serious trouble. Under appropriate diet, exercise, etc., the patient would improve.

DRS. JACKSON, FOX and ROBINSON suggested regulation of the patient's diet, so as to reduce his weight by training.

DR. ROBINSON thought that by this means the over-acid condition of the man's system would be removed, the imperfect circulation would be corrected and the tissues would be rendered able to resist the action of internal or external injurious agents, whether chemical or vital.

DRS. ELLIOT, FORDYCE and LUSTGARTEN were of the opinion that the patient could be cured by topic treatment, Dr. Elliot suggesting pyrogallie acid or strong solutions of resorcin or chrysarobin, and Dr. Fordyce strong ointments of sulphur and resorcin.

DR. CUTLER advised the application of the combination of carbolie acid, chloral hydrate and tincture of iodine in equal parts, followed by tar ointment.

DR. ELLIOT inquired why good results from training were to be expected in parasitic eczemas and not in other parasitic skin diseases, such as lupus, etc.? During the past seven years he had treated about 1,600 cases of seborrhœic dermatitis, and none of these had been influenced by internal treatment or by anything excepting such local means as destroyed the parasites.

DR. SHERWELL said he regarded the case as one of seborrhœal eczema. He had treated it with fairly strong remedies without much benefit. He was unable to see the patient very often, and had advised him to go into a hospital. He referred to the possibility of the eczematous patches developing into the lesions of mycosis fungoides.

#### A Case for Diagnosis.—Presented by DR. FOX.

The patient was a young man who had an eruption which had existed for seven years. It first appeared on the legs and gradually spread until now nearly the entire body is covered with it. It gives rise to burning sensations. The seasons do not seem to influence it. It appears to be a general erythema, but here and there are papules suggestive of lichen planus. Whether it was formerly a general lichen planus he could not say. There is none of the roughening of lichen planus on the lower extremities.

DRS. KLOTZ and CUTLER said they did not feel inclined to make a definite diagnosis, but could not recognize in the case any distinct features of lichen planus.

DR. CUTLER thought the case looked like one of urticaria or chronic erythema, if such a thing could exist.



DR. SHERWELL also regarded it as one of erythema.

DR. FOX said that some of the papules seemed almost typical of lichen planus. Dr. Jackson had called his attention to this fact.

**A Case for Diagnosis.**—Presented by DR. ROBINSON.

The patient was a woman, aged 32 years; married; one child; a native of Austria; personal and family history negative. She presents an eruption limited to the right side of the forehead and the temporal region of the same side. The first spots appeared about two years ago; new ones are constantly being added.

DRS. ELLIOT, FORDYCE and LUSTGARTEN made the diagnosis of *nævus verrucosus*.

DR. SHERWELL of sebaceous adenomata.

DRS. BRONSON, CUTLER, JACKSON and TAYLOR of *verruca*.

DR. CUTLER referred to a case he recently saw in which the lesions closely resembled those of the case presented, but were much more numerous, scattered over the face and neck down as far as the waist. In that case he made the diagnosis of *verruca plana* or *senilis*.

DR. KLOTZ regarded the case as one of *nævus mollusciformis unius lateris*, and called attention to its similarity to one of the same disease presented by him to the Society at the 211th meeting. The lesions were not verrucous at all, but presented a smooth surface and were quite soft. *Nævus unius lateris* was not always congenital and sometimes started at an advanced age. The lesions might microscopically be sebaceous adenomata.

DR. ROBINSON agreed with the diagnosis of *verruca*.

**A Case of Congenital Ichthyosis.**—Reported by DR. SHERWELL.

The patient was born on December 21, 1893. Breech presentation. On delivery the child was found to be covered from head to foot with hard epidermic scales and rough skin, with fissures through it here and there. The genitals were quite discolored, the labia majora being quite black, but these parts have since presented an almost normal appearance. The Harlequin picture quite marked. At present the anterior portion is still covered, and posteriorly, while there are no scales, owing to constant application of oil, the surface has the same ichthyotic appearance. The child nurses well, but seems to lose strength instead of gaining it. The family history is good, the mother having had four other children; two of these are now living and are healthy. One child was still-born and the other died under one year of age with cholera infantum.

DR. ROBINSON had since seen the infant and confirmed the diagnosis.

DR. FOX stated that he recently saw a case of variola in a patient who had general psoriasis. One eruption did not seem to exert any influence on the other.

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THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY. STATED MEETING, TUESDAY  
EVENING, APRIL 10, 1894.

DR. R. W. TAYLOR *in the Chair*.

**Vesical Calculi.**—DR. TAYLOR exhibited two phosphatic calculi removed from the bladder of a boy aged seventeen years. In both of these stones

the nucleus was composed of wax. The boy was an enthusiastic masturbator, and made a bougie of wax with which he titillated his deep urethra. In August, 1893, a portion of this bougie broke off and entered the bladder, and in February of the present year the boy began to complain of the usual symptoms of stone in the bladder. Supra-pubic lithotomy was performed and the calculi removed, together with some débris of wax found in the bladder.

DR. TAYLOR also exhibited a uric acid calculus in which the laminations of the consecutive deposits were beautifully shown.

**Renal Calculus.**—DR. JAMES R. HAYDEN exhibited a large renal calculus which had been passed by a patient *per urethra* immediately after a severe attack of renal colic.

DR. W. G. LEBOUTILLIER exhibited a kidney removed at autopsy, in the pelvis of which three calculi were found. During life the patient presented no symptoms of renal trouble.

DR. H. GOLDENBURG called attention to the fact that wax is often employed in the manufacture of urethral bougies, and if this fails to dissolve there is a chance for the formation of stone, as in Dr. Taylor's case.

DR. F. TILDEN BROWN referred to two cases of vesical calculi coming under his observation, in both of which the nucleus was chewing gum, which had been introduced for the purpose of masturbation.

DR. B. E. VAUGHAN gave the history of a patient who had attacks of renal colic extending over a long period, in which the symptoms were suddenly relieved by the spontaneous discharge through the urethra of a large calculus.

**Report of two Cases of Lithotomy.**—DR. CARL BECK gave the histories of these cases and presented the patients. The first patient was a young man upon whom six lithotomies had been performed for the removal of recurrent stones in the bladder. The first operation was performed when the patient was two years of age. Two months later, at a second operation, another stone was removed. Five years later there was a recurrence of symptoms and a large stone was removed by supra-pubic lithotomy, and a few years afterwards the same surgeon extracted another stone through a lateral perineum incision. During the past year the patient has been operated on twice by Dr. Beck for recurrent stone.

The second patient was a man aged 35, who had been under treatment for a long time for chronic cystitis without much improvement. When he came under Dr. Beck's observation there was frequent micturition and the urine contained pus. Perineal section was performed and the bladder drained, and within three weeks the pus disappeared from the urine. Five months after the operation the man was seized with a violent pain in the right lumbar region, which ceased abruptly after twenty-four hours, and a few hours later the man discharged a large stone through the urethra.

**Report of two Cases of Syphilis from Tattooing.**—BY DR. W. G. LEBOUTILLIER.

The first patient was a male, aged 25; single; denied venereal disease. On July 5, 1893, he was tattooed on both forearms. Eight or nine days afterward he noticed a pimple on the right forearm, which was indurated and gradually increased in size. Six weeks afterward a general eruption

appeared, with glandular enlargements, alopecia and mucous patches. In the second case reported the primary sore appeared three weeks after tattooing, followed by general secondary manifestations.

**Presentation of a Case of Artificial Testicle, with a Report of the Operation.**—By DR. RAMON GUITERAS.

The patient was a Frenchman, aged 32, whose left testicle was removed in Paris about five years ago for an inflammatory process, the exact nature of which Dr. Guiteras said he was unable to ascertain. In January, 1894, at the patient's urgent request, an artificial testicle was introduced. An incision was made in the scrotum in the line of the former cicatrix; the tunica vaginalis was then opened and stretched, so as to admit the artificial testis. It is made of celluloid and is one and one-quarter inches in length and three-quarters of an inch in thickness; its weight is 260 grains and it has a smooth ivory finish. The man suffers no discomfort whatever from the presence of the artificial organ.

**Tuberculosis of the Prostate.**—DR. B. E. VAUGHAN presented a patient with the following history: Male; aged thirty. One brother died of pulmonary tuberculosis. The patient had an attack of gonorrhœa and epididymitis about eight years ago. He came under Dr. Vaughan's observation a few days ago complaining that during the past four months he has suffered from frequent micturition and hæmaturia. A cystoscopic examination of the bladder proved negative. A rectal examination disclosed marked enlargement of the prostate. The first part of the urine passed is quite clear, while the last part contains a good deal of blood and a few particles of necrotic matter; no tubercle bacilli. Dr. Vaughan said he had been unable to arrive at a positive diagnosis; he thought it was a case of either tumor or tuberculosis of the prostate—probably the latter.

DR. EUGENE FULLER, after examining the patient, said he thought the case was one of tuberculosis, and advised large doses of cod liver oil. The seminal vesicles were enlarged and brawny and bound down by an inflammatory process. It was quite natural, he said, that the patient should pass blood, especially after instrumentation.

DR. VAUGHAN said the hæmaturia was most pronounced at the first visit, before any instruments had been passed.

DR. GEORGE E. BREWER said the man's symptoms might be due to a ruptured prostatic abscess. The fact that he is passing shreds rather pointed to that diagnosis.

DR. W. K. OTIS said he considered the case one in which there are multiple small abscesses in the prostate, the acute symptoms of which passed away some time ago. He did not find much involvement of the seminal vesicles.

**Some Common Mistakes in the Treatment of Syphilis.**—DR. GEORGE H. FOX read a paper on this subject. Many physicians, Dr. Fox said, hold to the belief that syphilis is an incurable disease. On the contrary, the disease in every case tends to run a natural course and get well of itself. If a patient suffering from syphilis inherits a sound constitution and takes care of himself, the prognosis is extremely favorable even though no treatment whatever is adopted. With the methods of treatment at our command, no disease furnishes such good results.

Another common mistake arises from the belief that mercury and potassium iodide are practically the only remedies we have at our command in the treatment of syphilis. While they are both very potent remedies, yet complete reliance on them often causes serious injury to the patient. In anæmic patients iron should be regarded as an anti-syphilitic remedy. In strumous individuals, cod liver oil is very serviceable. The alleviation of mental anxiety and the adoption of hygienic rules are of the utmost importance in certain cases. The mistake is too frequently made that we treat the disease instead of the patient.

Another fallacy is the belief that a certain definite period of time is required to effect a cure. Some say two years, others three, etc. The course of syphilis varies in different individuals, and the period of treatment must likewise vary, according to the severity of the case. One case of syphilis may require twice as much medicine as another, and the period over which treatment should be extended may be twice as long.

Another common error is that many ills occurring in a syphilitic subject are treated as though they were of syphilitic origin. The fact that a patient has syphilis does not exempt him from non-specific disorders, yet the physician is very apt to jump to the conclusion that such disorders are the result of the syphilis, and to treat them accordingly. In many cases lesions on the tongue and oral mucous membrane in syphilitics remain unaffected by specific treatment, and the fact should be borne in mind that similar lesions may occur in persons who have not had syphilis, as the result of digestive disturbance. Even if they are syphilitic, such lesions may persist in spite of specific remedies unless the digestive errors are corrected.

DR. C. W. ALLEN said that some cases of syphilis are of so mild a character that they would probably get well without much treatment, but taking all cases together, we cannot regard the disease as a self-limited one, and the propagation of such a view is likely to do harm. As regards the treatment of the disease, Dr. Allen referred to the good results derived from bathing, especially hot baths of natural spring water or sulphur baths. While mercury and potassium iodide are very effective remedies in the treatment of syphilis, still we have some reason to hope that the future will produce something better, perhaps in the way of an attenuated serum by which we can produce a specific vaccination. As regards the use of iron in cases where there is an anæmic condition, mercury is often superior to iron as a tonic. Dr. Allen said he did not agree with Dr. Fox that the disease should only be treated when symptoms present themselves; on the contrary, it should be treated in the intervals between such manifestations. Many of the persistent lesions on the tongue and oral mucous membrane are found in persons who use tobacco, which exerts a strong influence in keeping them up.

DR. BREWER said he agreed with the statement made by Dr. Fox that too much reliance is placed on the use of drugs, and too little on the hygienic conditions surrounding the patient, as well as his course of living. Both alcohol and tobacco will retard the recovery of these cases, and the speaker said he refuses to treat a case of syphilis unless the patient will agree to give up smoking and drinking alcoholic beverages for two years. Iron is often very serviceable and may be given in combination with mercury.

DR. E. B. BRONSON said that every one occasionally meets with cases of syphilis that have been maltreated. One of the chief dangers is excessive



treatment. The idea is held by many that mercury should be given at once and continued to the point of saturation. The same mistake is made in the excessive use of potassium iodide.

DR. P. A. MORROW said there is no doubt in his mind that if we study the natural course of syphilis, unmodified by treatment, we must come to the conclusion that it is a self-limited disease. We should have the courage to acknowledge the fact that treatment is not absolutely essential in all cases of syphilis. At the same time, the chances of immunity against future manifestations are much better among those who undergo specific treatment than among those who do not. On the other hand, there are many syphilitic conditions in which mercury and potassium iodide may do positive harm. Some cases of syphilis do not respond to these remedies. This is especially noticeable in cachectic and strumous individuals. It is very necessary that we should recognize that there are limitations to the use of mercury and potassium iodide in syphilis, although they are undoubtedly the best remedies we possess.

DR. J. A. FORDYCE said that in his opinion the greatest mistake we can make in the treatment of syphilis is to regard it as a benign disease. It is true that in the great majority of cases the disease is self-limited, but there is a certain percentage of cases which result in some serious or incurable lesion of the viscera or nervous system. As we are unable to say whether a case will prove to be benign or malignant in its manifestations, it is well to regard all cases as severe ones and treat them as such. Looking at syphilis from the standpoint of the dermatologist, who usually sees only its cutaneous manifestations, it is a benign disease, but many of its more serious sequelæ are seen only by the specialist in nervous diseases or the general practitioner. Certain malignant cases will persist in spite of treatment. Dr. Fordyce said he has never been able to obtain much benefit from the use of iron or cod liver oil in syphilis. If anæmia exists, it will usually disappear under the administration of mercury. There is no doubt that potassium iodide is often given to excess. He has known cases in which eight hundred to one thousand grains of the drug were given daily, and in two instances coming under his observation it has produced a fatal result.

DR. FULLER said he agreed with Dr. Fordyce that syphilis should be regarded as a severe rather than as a benign disease. In strumous cases he has found that cod liver oil in small and frequently repeated doses seems to act well. Tobacco he regards as an extremely potent agent in perpetuating the mucous lesions in the mouth. Dr. Fuller condemned the practice of instituting treatment in the very earliest stage, with the idea of heading off the disease. In this way harm is done by obscuring the symptoms and making the diagnosis uncertain.

DR. W. K. OTIS said he did not think we have any remedies for syphilis at our command excepting mercury and potassium iodide. He regards syphilis as a self-limited disease in every instance. Tertiary syphilis cannot be regarded as syphilis proper. A man may develop tertiary lesions twenty years after the date of the original infection, after he has lived with a wife who has never contracted syphilis, and after he has raised a family of healthy children. As regards the treatment of syphilis, Dr. Otis said in his opinion it should be commenced early and continued during the intervals between the manifestation of symptoms. If a patient is debilitated or strumous those conditions should be treated in exactly the same way as they are

treated in non-syphilitic persons. Extremely large doses of potassium iodide, the speaker said, are only allowable in cases where a vital organ is at stake.

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## Book Review.

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*Syphilis in the Innocent (Syphilis Insontium).* Clinically and historically considered, with a plan for the legal control of the disease. By L. Duncan Bulkley, A.M., M.D., Physician to the New York Skin and Cancer Hospital, Consulting Physician to the New York Hospital, Lately Professor of Dermatology New York Post-Graduate Medical School and Hospital, etc. New York: Bailey & Fairchild, 29 Park Row.

After ten years of research, examination of the records of cases and epidemics of non-venereal syphilis in various parts of the world, the compilation of a vast amount of statistical data, and the elaboration of the whole into an essay, the author now presents the results of his labor to the public.

One cannot help being impressed with the immense amount of research which must have been required to produce so complete an analytical bibliography as that presented in the hundred and forty-five pages given up to this feature of the work. That such collection and classification of all that has been published upon the question, as well as the "Synopsis of facts and literature," to which thirty-two pages are devoted, is of value to all interested in the subject, cannot be gainsaid, but while we admire the energy expended we are not prepared to admit that it makes interesting or even very instructive reading. The first half of the work, however, contains much that is entertaining. The early chapters take up modes of diffusion, geographical distribution, forms of syphilis and location of extra-genital chancres. Then follow the condensed histories of one hundred and thirteen cases, which have come within the author's personal experience, arranged according to the region in which the primary lesion occurred. Succeeding chapters treat of methods of spread of syphilis in the past and present, epidemic and endemic syphilis, with a table recording one hundred and ten epidemics chronologically arranged. This will prove of considerable historical interest and will be useful for future reference.

Endemic syphilis and the various names under which the disease has been known in different countries is considered at some length.

Chapters VII., VIII. and IX. treat of the various modes of accidental infection, and Chapter X. of medico-legal considerations, prevalence, prophylaxis and legal control.

Unquestionably some means should be devised to limit the spread of the disease and protect the innocent.

No definite plan of action is formulated by the author, but some excellent suggestions are made, such as the placing of syphilis among the other contagious diseases which come under the jurisdiction of the health officers, "to make it quite as criminal to transmit syphilis wittingly as to communicate small pox, scarlatina or diphtheria," "to examine the men," etc. Similar suggestions have been made before in this country, but have hitherto

had no noticeable effect upon legislative action. Syphilis is considered by the author to be undoubtedly on the increase, while infection by lactation and other recognized accidents is yearly becoming less frequent, and still innocent syphilis, as a whole, would appear not to be on the decrease.

If this work aids, as it undoubtedly will, in bringing about means of restricting the spread of non-venereal syphilis, a useful mission will have been accomplished. The vast majority of syphilitics can still exclaim with the psalmist "before I was afflicted I went astray," but the number who yearly fall victims through no fault of their own is unquestionably large, and something should be done to make the disease less dangerous to the public.

C. W. A.

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## Selections.

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**Parasites in Cancer.** NEPVEN. (*Archives de Méd. Expér. et d'Anat. Path.*, January, 1894.)

According to the observations of this investigator there are several varieties of parasites found in the growing parts of carcinomatous tumors; numerous free or intracellular (intranuclear) spores which he calls sporiferous cells—special cells whose nucleus is divided into four parts and offers reactions absolutely distinct from all other cells (endogenous tetragenesis); cystic cells situated in the lymphatic radicles and which enclose at least four sporoid cells; amœboid cells filled with six or more sporoid cells; cells dotted with nuclear masses, free or not, amœboid and going through the same evolution; proliferating cells whose karyokinesis does not explain the genesis; cells which contain spores "mounted on a filament like a musical note"; cells which recall hydatids by their appearances; cells with striated borders, etc., etc.

All the appearances are not explained by karyokinesis, even pathological. They are better explained by the presence of a sporozoon whose characteristics are not well known, but around which the circle of observation seems to move ceaselessly, continually narrowing.

The author further expresses his conviction that amœbæ sporozoa and bacteria make cancer a neoplasm of parasitic nature. Bacteria must play some rôle in these tumors and give rise to some part, at least, of its pathogenic action. The belief in the existence of the latter is not incompatible with the presence of protozoa. The parasites described are illustrated in a colored plate.

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## THERAPEUTIC NOTES.

**Massage in the Treatment of Prurigo.**—Eleven cases, seven of a severe form, four milder, have been benefited by this procedure in the hands of R. Hatschek, of Vienna. His method of application is a simple rubbing of the diseased surface, beginning at the distal end, if it is an extremity and working toward the center. The séances at first last from ten to fifteen minutes, and are repeated daily. As improvement goes on the length of time

is shortened to three or four minutes. In all the cases the intolerable itching was quickly relieved, and the dermic infiltration reduced. In case of relapse the massage was again applied, and was employed as a preventive of future attacks. Two or three weeks, the author claims, were sufficient to cause complete disappearance of the prurigo. When complicated by eczema, the rubbing seemed to exert a beneficial effect on the latter also. (*Archiv. f. Derm. und Syph.*, 1893, XXV., p. 931.)

**Arsenic in Recurrent Herpes.**—HUTCHINSON is of the opinion that in this drug we have a means of controlling successive attacks of herpes. He gives a record of a case of "herpetiform pemphigus" in which formation of blebs was completely arrested by exhibition of arsenic. The disease returned when treatment was intermitted, but a continuance for two years produced a practical cure. (*Archives of Surgery*, July, 1893.)

**Chlorinated Lime in Pruritus Ani.**—ALBERT K. BERGER, of Krementchüg, claims brilliant results in the treatment of this rebellious affection. He introduces into the anus a pledget of cotton soaked in liquor calceis chloratæ, leaves it there and withdraws it when a slight smarting begins. The region should be washed in the solution and left undried. Itching disappears as if by magic, but the proceeding must be repeated when it returns. (*St. Louis Med. and Surg. Jour.* from *Zemsky Vrach*, No. 13, p. 213, 1893.)

**Condylomata Acuminata Treated with Pure Carbolic Acid.**—DEVILLE applies the liquefied acid to the genital warts, covering adjacent parts with vaseline, repeating the operation when the scab drops off. He claims a certain and prompt cure. (*La Semaine Médicale*, 1893, No. 35.)

**Internal Treatment of Vesicular Eczema.**—Noting the failure of local measures to prevent recurrence and extension of disease in the vesicular form, Phillips has been led to try the effect of various internal remedies. The failures, as must be expected, outnumber the successes, and these latter are very moderate.

Ichthyol, in pill form, was useful in a few cases, one, particularly, in which relapses were frequent. Tartar emetic, in doses of one-tenth to one-sixth of a grain, t. i. d., was often of great service, but must be given for long periods. The hypophosphites occasionally gave good results. Calcium sulphide, calcium chloride and thyroid extract were useless or worse. (*Brit. Med. Journ.*, January 27, 1894.)

**Peroxide of Hydrogen in Stomatitis.**—BOENNECKEN prefers this solution in strength from two to five per cent. to solutions of potassium chlorate or permanganate, especially in febrile and wasting diseases. It destroys fetor in a short space of time, it is non-irritant, and if used continuously the buccal mucous membrane will show decided improvement in twenty-four hours.

In discussing the paper, Leo stated that his results were also good with the drug. Walters praised its effect in 5 to 10 per cent. solutions in mercurial stomatitis; but Bing regarded potassium chlorate as equally effective. (*Deut. Med. Wochenschrift*, January 11, 1894.)

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## Original Communications.

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EXFOLIATION OF THE MUCOUS AND SUB-MUCOUS COAT OF  
THE BLADDER PRECEDED BY RENAL AND VESICAL CALCULUS.<sup>1</sup>

BY

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WE are familiar with the exfoliations of the mucous membrane from the uterus, vagina, larynx and other mucous tracts. Those of the urethra have been recorded under the names of "membranous desquamative urethritis," "urethritis squamosa," "membranous urethritis," "croupous exudation." And yet the cases thus recorded were not any of them attended with the symptoms of urethritis. I have in mind two cases which I saw some years ago in which membranous casts were formed in the urethra and discharged as they became detached, the shreds projecting, as they did in one instance, as dry masses from the meatus, from which they could be readily withdrawn. These desquamations were not attended with any marked discomfort, or with the usual symptoms of inflammation, though both patients admitted having had gonorrhœa several months before, for the cure of which they had recourse to powerful astringent injections. The urine was repeatedly examined and found normal in composition. There were no constitutional symptoms such as one would expect would follow in the train of diphtheria. That complete exfoliation of the mucous membrane of the

<sup>1</sup> Read at Eighth Annual Meeting of the American Association of Genito-Urinary Surgeons, June 1, 1894.

bladder may occur has been repeatedly denied, and that quite recently. This, I presume, only because of the veiled nature of the process, for the fact of its occurrence is attested by an array of at least fifty cases on record (*vide* our appended bibliography), not adding the typical specimens preserved in some of the hospital museums in this country and abroad. A few text books, it is true, mention cursorily a diphtheritic and a croupous cystitis, but with these the cases collated have nothing in common.

Not only the entire mucous membrane has exfoliated *en masse*, but portions of the muscular coat have come away as well. In one case the entire mucous coat was shed in the form of a sac, and, after an interval of some days, a portion of the muscular tunic was cast off separately. Morez cites a case (with a favorable termination) in which a portion of all the coats, including the peritoneum, was necrotic and came away. In this case the assumption is, of course, necessary that an adhesive pericystitis occurred before the sloughing took place. The real question at issue, therefore, is not *whether* exfoliation occurs but *how* it occurs; not the effect but the cause.

Reasoning from analogy, we infer that, when a mucous surface is subjected to prolonged or intense irritation, as after the employment of powerful urethral injections as in the cases of gonorrhœa above mentioned, or the presence of ammoniacal urine in the bladder, will, as it modifies the vitality of the epithelium, favor its exfoliation. The epithelia of the bladder have a longer life history than elements of their class usually have. We infer this from the fact that we do not find many vesical epithelia in normal urine. The few scattered cells which are seen are mostly derived from some other portion of the urinary tract (glandular, etc.). The general impression that such cells are vesical epithelia, which, after detachment have undergone transformation by contact with the urine, is negatived by the fact that vesical epithelia may be kept in fresh urine for a long time without in any way losing their characteristic appearance. After undue distension, however, the mechanical pressure effects a change in the shape and the thickness of the epithelia. The cells are not alone altered in their physical, but also in their vital properties. There are instances on record in which the epithelium of the bladder seemed to have undergone dermoid transformation. Posner (*Virchow's Arch.*, vol. 118, 1889) cites the case of Marchand, and in the cases presented here by our colleagues, Fordyce and Cabot, the membranes removed

were made up wholly of sheets of epithelium. In these cases there was some local irritation to account for the hyperplasia and cornification of the epithelium.

In looking for an explanation of the shedding of the mucosa *en masse*, several possibilities suggest themselves. In the first place, we all know how loosely the greater portion of the mucosa is attached to the underlying tissues, and how easily we can dissect it off from its annexes when called upon to do so in the removal of sessile growths from the bladder. Furthermore, in the autopsy room we not infrequently see blood extravasations in the sub-mucous areolar tissue, notably when some obstructive condition existed to the return circulation from the viscus, causing passive congestion, raising the mucosa in ecchymotic patches. Sometimes these extravasations are trifling, yet they are the only pathological manifestations that we can discover to account for the distressing irritability of the bladder during life. And, if these extravasations spread over an extended area of surface, devitalization of the mucosa may ensue, and a necrotic slough will be detached.

Secondly, cystitis limited to the mucosa disappears rapidly with the removal of the cause which occasions it, but not so in the parenchymatous form. Here the tunics are infiltrated with inflammatory products not so readily disposed of.

Thirdly, the normal mucous membrane is pale, non-vascular. The blood supply to the bladder is distributed chiefly to the muscular and but sparingly to the mucous coat, an anatomical disposition contrary to what is observed in other hollow viscera.

Fourthly, the fact that the arterial supply is mainly through the base of the organ, and that the return circulation is effected by virtue of a dense plexus of veins situated also in the region of the vesical neck and *bas fond*, we can readily understand that any extra-vesical pressure on this part will interfere materially with the nutrition of the organ. Then add to this an opposing force, the intra-vesical pressure of the retained urine, and we have existing conjointly the factors which will cause a stagnation in the circulation of the viscus. Whether or not the hydrostatic pressure on the stretched mucosa, effacing its rugæ and compressing its submucous coat and blood-vessels, is sufficient in itself to cause the exfoliation, it remains that the chief etiological factor given is almost invariably the same, namely, "*retention of urine*." Of the fifty cases we find

forty-five were females and but five males. In all of the former the retention was due to a retroverted gravid uterus, or else the pressure of the child's head in prolonged labor. Invariably, therefore, in parous women. The significance of this will be apparent, always to keep in view the topographical relationship of the bladder to the uterus during pregnancy and during parturition, its dislocations, the diminution of its capacity, etc. The disparity in the sexes in this respect is said to be only apparent, not real, in that, in women, owing to the shortness and great dilatability of the urethra the membrane is extruded, and is more frequently recognized. But I think a more philosophical reason is that in women both the extra- and the intra-vesical forces are in operation, while the male bladder very rarely meets with any embarrassments from without. Its trouble is all from within. Men suffer from retention, due as a rule to some obstructive disease of the urethra, and, in view of how frequently they are victims of this condition the inference is unavoidable that the hydrostatic pressure—the retained urine *per se*—is an insufficient factor, notwithstanding the experiments on dogs by May (Inaug. Dissert., Giessen, 1867) in which the retention hypothesis would seem to receive confirmation. In a number of instances it was especially noted that the mucosa was found detached at all points excepting at the *bas fond* and vesical neck, where it was still adherent for the reason, no doubt, of the more intimate connection of the structures at this, the fixed part of the bladder. The cast-off shreds have usually a gritty feel, and are covered with a phosphatic deposit which means that, as the result of the retention and the ammoniacal decomposition of the urine, the mucosa has been denuded of its epithelium, loses its polish, and the triple phosphates are precipitated and cling to the roughened surface with great tenacity. Once a calcareous plate formed, it rapidly grows by accretion, and may then mechanically devitalize the immediate surroundings. Whether such has been the history of the case about to be related I must leave you to determine.

The prognosis in women is good. The exfoliated membrane is often expelled *per urethram, en masse*, and so ends her trouble. Of the forty-five cases but nine have died (one-fifth of the number), and in these the lethal termination was not altogether attributable to the vesical lesion. In men the reverse is the case. The conditions which give rise to the exfoliation are in themselves grave, independent of the bladder trouble. Two of the five patients (Southam's and Clarke's) died. Three



(Liston's, Marchand's and Cabot's) recovered. In the two latter, however, the exfoliated membrane, as has been said, was only epithelial. Complete recovery occurs in some of the most unpromising cases, but if so there is apt to remain, for a time, until repair has taken place, some disturbance of co-ordination between the retentive and the expulsive forces of the bladder. One or the other of these will be affected, as the mucous membrane is detached from the vertex or in the vicinage of the vesical neck, or, in other words, as the end organs of nerves are torn away the bladder becomes incapable of responding to its accustomed stimuli of retention or expulsion. Where only the mucosa and submucosa have been cast off it is not nearly so telling as one would, *à priori*, expect on the functional activity of the organ as when a portion of the muscular tunic has come away as well. The remarkable absence of pain noted in many cases after exfoliation may be attributed to the same cause, the removal of the end organs.

The history of the case is briefly as follows: Male, æt. 26. Has had frequent attacks of renal colic since he was seventeen years of age. Always referred to the left loin. He had no attacks during the years 1882, 1883 and 1892. During these years he felt absolutely well but repeatedly passed fragments of stone, without having any pain or discomfort. In the Spring of 1893 had an attack of retention which lasted about twenty hours. He noticed when retiring for the night that he could not micturate. His bladder became painfully distended, and he was unable to pass any water, although he made frequent attempts to do so during the night. In the morning he got up, and, after making several unsuccessful attempts, became, as he says, "desperate, and drank a whole tumbler of gin." Soon after he passed a stone of a yellowish color, easily crumbling beneath the fingers, and this was followed by a large quantity of bloody urine. Patient measured the stone, and found it one and one-half inches long, with the circumference of an ordinary lead pencil, and tapering at both extremities. The pain ceased after the passage of the stone, but the urine remained bloody for several days. The first passed would be clear, the last bloody. Has had repeated attacks of nephritic colic since, always in the same region, always within an hour after the paroxysms of pain were over, he passed from one to four calculi the size of a pea, and in consistence like that first passed. During the intervals of the paroxysms he felt perfectly well. About this time, Spring of 1893, there gradually

developed a swelling in the left lumbar region. It was about two weeks in making its appearance, and then very suddenly disappeared. Immediately afterward he passed a "yellowish fluid, thick-like matter," and, on examining the deposit twenty small pieces of stone were found, these having apparently the same composition as those previously passed. From this time to the present patient dates his classical symptoms of stone, namely, frequency in micturition, sudden arrest of the stream, pain at the end of the penis, the slightest jar producing discomfort, etc. Examined with searcher, and found calculus at once, September 15, 1893; patient being anesthetized, litholoxypaxy was performed; the detritus removed was composed of ammon. magnes. phosphates, and, when dry, weighed 220 grains. His relief was immediate, and so great that he returned to his country home three days after the operation. September 30th, called; says that he has been feeling so much better of late that he resumed his occupation six days ago. Has omitted to wash out his bladder because he did not think it necessary, although given special instructions to do so. There is some pain at the old site occasionally, and, for several days, has noticed a frequent desire to micturate. Urine alkaline, contains some pus corpuscles, and a trace of albumin. Examined and irrigated the bladder, without detecting any fragments of stone. Is directed to have the bladder washed out once or twice daily with a one-tenth p. c. sol. of salicylic acid. October 30th, received a letter in which he writes: "I have a great distress in my left side. Pass thick, fleshy particles which are so large that it would seem hardly possible for them to pass through the canal. It stops my water entirely at times, so much so that I have to use a catheter to get relief." November 2d, he seeks relief from his sufferings, which are now very intense. Micturates hourly, with excruciating tenesmus. Urine very offensive, strongly ammoniacal, abundance of a ropy pus, shreds of membrane come away, often so large that they occlude the urethra, necessitating the employment of a catheter to dislodge them. Temperature always high, at times 105, which is supposed to be due to the acute nature of the process and to septic absorption from the bladder. Had his bladder irrigated with a one-fifth p. c. sol. of salicylic acid twice daily, but refused all cutting operations. Notwithstanding that the symptoms improved, the shreds of membrane wholly disappeared from the urine, or the washings from the bladder, and he went home again November 10th. I did not see or hear

from him again, but was informed that he died rather unexpectedly the early part of December. In what manner and from what cause I have been unable to learn, except that he was "stupid and sleepy for some days previously." Presumably he was uræmic.

In summing up this suggestive history we find that the nephritic colic was invariably referred to the left loin. About six months before he came under observation he had retention of urine, in consequence of the impaction of a calculus in the urethra. Shortly after this there occurred an intra-renal distension from impaction, in either the pelvis of the kidney or possibly at the vesical extremity of the ureter. A swelling appeared in the left lumbar region, which was doubtless a hydro- and a pyo-nephrotic tumor, and not connected with the spleen, as was thought at the time by the attending physician. After stagnation of the urine in the pelvis of the kidney, alkaline fermentation obtained, and pyelitis was excited, which, after the dislodgement of the offending calculi, and the emptying of the pyo-nephrotic sac *per viam naturalem*, there was left a favorable nidus for the subsequent formation of crystals of ammon.-magn.-phosphates, which, after descending into the bladder, continued their destructive work. Trauma will suggest itself as a possible factor in causation, but I am disposed to eliminate an injury done at the time of the operation, because of the facility with which the stone was comminuted and the fragments washed out; the stone was so extremely friable that the operation was very expeditiously performed, with as little instrumentation as possible, and for about a month subsequently the relief from all his symptoms was so marked that he considered himself well. Then gradually an accession of cystitis occurred, which was followed after a time with the appearance of the exfoliated shreds of membrane. These he continued to pass more or less with each act of micturition for at least *two weeks*, in such quantities as to represent the entire lining of the bladder. The occurrence of retention was, I think, too remote, and was not sufficiently severe or prolonged to account for the exfoliation. It is more probable that the process was due to a sequence of causes, consecutive to pyelitis. The constant irrigation of the mucous lining with ammoniacal urine, the contact of small, sharp fragments (coming from above) with the membrane already disposed to inflammation, and finally, the infiltration of the products of inflammation in the sub-

mucous coat all contributed their share to bring about the result. I regret that he did not allow us to open the bladder from above, for I am confident that the antiseptic irrigation and the drainage would have afforded him great relief, and incidentally, the pathological question would have been solved how much the exfoliation was due to inflammatory, and how much depended on mechanical causes? From the history given, there is reason to believe that he did not die of his bladder lesion, for that was much improved, and continued to get better when I last saw him, but rather that the cause of death was due to atrophic, if not inflammatory changes in the secreting structure of the left kidney, and the one on the other side did not, or was unable to take on compensatory function.

I present herewith some of the shreds passed by patient. The microscope reveals them to be more than pseudo-membranous or diphtheritic in their nature. The mucosa and the sub-mucosa have lost their vitality and have sloughed off entire without there being any evidence of molecular death apparent.

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## A FURTHER CONTRIBUTION ON AN "EPIDEMIC SKIN DISEASE."<sup>1</sup>

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### INTRODUCTION.

IN November, 1891,<sup>2</sup> I ventured to draw attention to a form of skin disease which under certain circumstances is contagious, and was at that time epidemic; and the constant presence of a microbe was demonstrated by Dr. J. R. Russell<sup>3</sup> and myself.<sup>4</sup> I defined the disease as a contagious malady in which the main lesion is an inflammatory condition of the skin, sometimes attended by the formation of vesicles; always re-

<sup>1</sup> Presented to the Eleventh International Medical Congress, in Rome, March 31, 1894. With the Exhibition of Photographs, Colored Sketches, Microscopic Specimens and Flakes of Epidermis.

<sup>2</sup> *British Medical Journal*, December, 1891, and January, 1892; Medical Society's Transactions, 1892, *British Journal of Dermatology*, February and March, 1892; and a monograph obtainable from the author or from Messrs. H. K. Lewis, Gower Street, London.

<sup>3</sup> *British Journal of Dermatology*, April, 1892.

<sup>4</sup> *British Medical Journal*, January 9, 1892.

sulting in desquamation of the cuticle ; usually accompanied by a certain amount of constitutional disturbance, though without pyrexia, and running a more or less definite course of seven or eight weeks. One hundred and sixty-three such cases occurred in patients under my care, which arose in the Paddington Infirmary during the Summer and Autumn of 1891.

It had certain very marked resemblances to eczema, for which disease I, in common with others, at first mistook the malady ; but afterward it was evident that it did not always correspond to eczema, even apart from its character of epidemicity.

An admirable description of the chief features of the disease is given by Dr. Byron Bramwell, in his "Atlas of Clinical Medicine," (1893, volume II., part III., page 121), which contains also two beautiful colored illustrations of patients suffering from the malady.

The disease is, so far as I am aware, the only skin malady up to the present time which has been connected with epidemic causes. In 1891 the disease broke out in six institutions in London (giving 424 cases), and many isolated cases occurred in the medical practices of my friends. The importance and severity of the outbreak in that year may, in some degree, be estimated by the fact that 12.8 per cent. of the 163 cases under my care died. The entire body was covered with the eruption in one-half of these cases.

During the past three years I have, when opportunity offered, devoted myself to a study of the malady. I propose in this paper to embody the material collected during that time. On the whole, there is not much modification to be made in the description of the disease given in 1891.<sup>1</sup>

<sup>1</sup> It may be well to reproduce here the history of a fairly typical, though *very severe*, case, lest the original account of the disease should not be readily accessible to the reader.

D—, æt. 63, was admitted to the Paddington Infirmary on March 13, 1891, with pain, swelling, and other symptoms pointing to rheumatic inflammation of some of the joints and fasciæ of the right arm and leg. By the end of June he was quite well, getting up and about every day. His discharge from the infirmary was in contemplation, when (on July 4th) he complained to the nurse of considerable "irritation" of his skin, especially on the arm. There was nothing to be seen at the time, but the next day a fine papular rash was observed on the front of the right forearm and upper arm. The rash came out as a thickly set papular one with some general congestion and thickening of the skin. By the sixth day (July 10th), the eruption had spread to the face and head. Next day fresh independent patches of the disease were observed on the palms, the left elbow back and front, and also on front of the legs, a point still more distant from the place first attacked. Meantime the parts originally attacked underwent improvement. It was never vesicular, but the epidermis was soon universally shed as small dry scales, or in larger flakes from the hands and feet.

It will appear from the facts about to be mentioned—first, that the epidemic of 1891 was an unusually severe one, both as regards the type and the number of the cases; second, that cases of the malady may arise sporadically, and sometimes in a very mild form; third, that it is not a rare disease; and, finally, that the name "General Exfoliative Epidemic Dermatitis," besides being cumbersome, is not altogether appropriate.

Further light is still needed on the pathology and nosology of the disorder in question and it is with this end in view that I submit the following facts to the criticism of the medical profession.

Since 1891 four outbreaks have come to my knowledge, and we will first examine these, subsequently passing to a consideration of the sporadic cases.

The eruption took a turn for the better about the tenth day, and it was thought to be getting well; but about the fourteenth day there was a severe general exacerbation. The eruption was now symmetrical and noted (July 17th) as "very burning and irritating, and preventing sleep. Back covered almost uniformly with papular eruption which is going on to furfuraceous desquamation. Arms and legs covered with spots of same, also hands up to fingers' ends, back and front. Face and most of scalp (both bald and hairy parts), uniformly reddened and thickened (not papular) and desquamating in small scales. Ears worst part of all, and weeping."

The only place where vesicles were observed in this case was behind the ears; elsewhere the vesicular stage, if it existed at all, escaped notice. By the twenty-first day nearly the whole of the body and limbs were affected, and presented the appearance of *a crimson surface formed of inflamed and swollen skin, gradually being denuded of its epidermis, which separated in scales and flakes of various sizes; and presenting here and there, especially in the flexures of the joints, cracks through which a scanty moisture exuded*; but otherwise, and for the most part the inflamed skin was dry, and it felt hot. The conjunctivæ were inflamed and discharged a sero-purulent fluid, and a sickening odor was given off from the skin.

Matters remained in this pitiable state for several days. The skin was raw and acutely tender to the touch, so that the patient dare not relieve the intolerable itching and burning from which he suffered, and the mere contact of the bed-clothing was painful. About the twenty-fifth day of the eruption the swelling began to abate, but the redness and desquamation still continued for some weeks longer. On August 12th the following note was made: "Eyelids much thickened, eyes red and watering. Whole surface of body reddened and scaling in moderate-sized scales." Mr. Jonathan Hutchinson saw the patient about this time, in the sixth week of the disease, and expressed the opinion that it would be "difficult to distinguish the case at that stage from one of pityriasis rubra;" the universal desquamative dermatitis was exactly such as occurred in that disease.

About the seventh week the new skin gradually assumed a yellowish-brown color, and an appearance of being stretched and dry, like parchment. In the face this stretching gave rise to eversion of the eyelids. This stage lasted some time, and it was not until the eighth or ninth week that the skin reverted to its normal condition, though still somewhat scurfy.

During the whole time the patient suffered from extreme weakness and prostration; at one time he experienced a feeling as of "falling through the bed." The tongue, at first coated, afterward became raw and sore, like the skin. The loss of appetite was very marked, amounting to a loathing of food. He sometimes felt sick, though he never vomited, and he had no diarrhœa. The weakness lasted long (several weeks) after the dermal inflammation had abated, but return of the appetite was the direct sign of improvement,

*Section I.—The leading features of the disease—Exfoliation and definite duration—Outbreaks since 1891.*

(A) Cases in the Paddington Infirmary, 1892.—The 163 cases on which I based my observations in 1891 all occurred among the patients and staff at the Paddington Infirmary and the adjacent Workhouse. In the Spring of 1892 these buildings were very thoroughly distempered and cleansed; nevertheless, I had under my care 12 fresh cases which arose in the Infirmary, and two admitted from the outside, in the Summer and Autumn of that year. Five of them had been previously attacked in 1891. This gave an attack rate of approximately 2 per cent. as compared with 19 per cent. the year before. Twelve of the cases in the Infirmary were males and two females. As in the previous epidemic the aged chiefly were attacked, though one man was only 30, another 38, and another 40. The eruption started on different parts of the body in different patients. One case, a woman (Fanny Moore), aged 38, had a fatal issue. The disease attacked her in March, 1892, while she was in the sick wards of the Workhouse, and after several relapses, and after a very chronic course, she died of asthenia on September 30th. She was the subject of very advanced cardio-vascular changes.

Mr. J. J. Clark, of St. Mary's Hospital, very kindly endeavored to cultivate the microbe from some blood which I obtained from the left ventricle, but was not successful. It was possible that too elaborate precautions were taken to sterilize my operations in obtaining the blood, and that some corrosive sublimate was allowed to get into the capillary collecting tubes. But I have before had great difficulty in obtaining the microbe from such chronic cases as this. The best for such investigations always seemed to be the more recent cases.

and it became as ravenous as in a patient recovering from typhoid fever. The temperature taken regularly throughout was very little if at all elevated, going up to 99 on some evenings. The urine, which had been normal on admission, presented a trace of albumin on several occasions. It first appeared in the fourth week of the disease (July 28th), and lasted continuously for six or seven weeks after recovery, to October 6th, when it disappeared. Concurrently with this there was anasarca of the legs.

The primary attack of the disease may be said to have lasted about eight weeks altogether. The eruption was followed on two occasions by trivial localized relapses, viz., two weeks later (September 17th), on the arms and chest, and eight weeks later (October 23d), on the legs. Three weeks after the rash faded he had a slight attack of pleurisy.

The marked abatement of the eruption during the second week in this case is a feature worthy of attention. A similar abatement, followed by an exacerbation of redoubled violence has occurred at an early stage in many of the cases.

In this patient the nails were shed, and the hair of the scalp came out, so that he became completely bald, and the eruption was followed by a chocolate-colored pigmentation uniformly spread over the whole body.



A marked instance of the contagiousness of the malady occurred in the case of Jeremiah W., aged 40, a man admitted on September 3, 1892, for a severe bruise of the leg. One may say, in passing, that the patients themselves were fully persuaded of the contagious nature of the disease, and this man was in great fear of catching it. He was up and well, when several other cases of the skin disease on inmates, on whom he sometimes tended, were active in the ward. On September 15th, *i. e.*, twelve days after admission, his skin began to itch, and on the 17th he developed the rash as an urticarial or blotchy one, at first on the scrotum and thighs, afterward spreading to the legs, abdomen and chest. Creolin baths and ichthyol soap did him good, and he left of his own accord, with the rash still on him, on October 18th. Almost from the first the patches took on an eczematous character, with exudation; and a few days later resulted in dry, branny desquamation of the cuticle. The eruption throughout was in patches or maculæ, but little raised. The distribution was almost general, but chiefly over thighs and lower trunk. The temperature throughout was slightly below normal, and the only constitutional symptom was weakness.

William S., aged 66, being a typical acute case, may here be briefly referred to. A discrete papular rash on the arms, and a papular erythematous eruption on the legs appeared simultaneously on August 20th. In twenty-four hours it became general and assumed different types on different parts of the body. On the arms it remained dry and became scaly. On the legs and trunk there was much exudation and swelling of the skin, which cracked in places, and it terminated in exfoliation of the cuticle in large flakes.

The conjunctivæ were very much swollen and often painful. The temperature varied between 99° and 100° F. during the first few days; there was also thirst, loss of appetite and prostration. Urine normal. He improved at once with the first creolin bath, and continued to do so steadily. Soon after the advent, purpuric patches appeared on the legs. He suffered a good deal at first from the tension of the skin on the legs and thighs. The arms relapsed seventeen days after the commencement, but he made a good recovery in seven or eight weeks, though the skin still remained stretched and parchment-like in appearance.

Detailed notes of all the cases which occurred in the Paddington Infirmary during the year 1892 are preserved in the Clinical Records of the Infirmary, and a Table of the Cases,

which need not be reproduced here, was made with columns for the following headings: 1, name; 2, age; 3, ward bed; 4, date of commencement of disease; 5, part first affected; 6, character of initial rash; 7, progress and extent of rash; 8, type (moist or dry); 9, character of desquamation; 10, other epidermal structures involved; 11, relapses; 12, subjective symptoms; 13, temperature; 14, tongue and intestinal symptoms; 15, anorexia or asthenia; 16, urine; 17, pulse and respiration; 18, other organs involved; 19, date of recovery or death; 20, mode of recovery or death; 21, duration of primary attack; 22, complications and sequelæ; 23, treatment and its effect; 24, remarks.

Summary of Paddington Cases, 1892.—The ages of the fourteen cases under my care in the Infirmary in 1892 were respectively 30, 38, 40, 42, 44, 50, 60, 60, 63, 66, 67, 70, 78 and 79. Two of them, as before mentioned, *were attacked in their own homes outside the Infirmary*, and of the remaining twelve three arose in the sick wards of the Workhouse and nine in different parts of the "New Paddington Infirmary."

As to the date of commencement, two started in January, two in March, two in May, two in June, one in August, three in September, one in October and one in November. The eruption began on different parts of the body, but mostly on the lower extremities, and generally commenced as a discrete papular rash, grouped into constellations. One case was urticarial and one erythematous.

In about one-half of the cases the total skin area was affected. About half of the cases were of the dry, and half of the moist type. All the attacks were less severe than the year before, and only one patient died, a woman of 78, who was the subject of advanced cardio-vascular disease. Two of the cases in whom the rash was extensive had, at first, a slight elevation of temperature; the others had no constitutional symptoms if we except weakness and loss of appetite.

(B) Cases in the Paddington Infirmary, 1893.—In 1893 Dr. T. E. Hillier succeeded me as Medical Superintendent at the Paddington Infirmary, and six cases occurred in the patients under his care, an approximate attack rate of 0.6 per cent. as compared with 2 per cent. in 1892 and 19 per cent. in 1891.

Thanks to the courtesy of Dr. Hillier, I had an opportunity of seeing and identifying some of these cases. The following particulars were taken from the notes kindly supplied to me by Dr. E. H. Snell, the Medical Officer, who further informed me

that there were one or two others in the sick wards of the adjacent Workhouse of which he was unable to supply notes.

The ages of these six cases were respectively 59, 65, 66, 73, 74 and 93. All of them were in the New Infirmary when first attacked with the disease. Two arose in June, one in July, two in August, one in September. In two, the eruption started simultaneously on the hands and feet, one on the arms, one on the neck and arms, one on the legs, and one on the face.

In all it began as a papular rash. There was a large extent of surface involved in all, but none were quite universal.

Two cases had more or less exudation; the other four were of the dry, desquamative type. In all other respects they conformed to the moderately severe type of the disease. All complained of anorexia and of weakness. The temperature in four of the cases was subnormal, and in none was it elevated. All six had traces of albumin in the urine, one woman, aged 73, having previously suffered from renal disease. In no instance did the disease prove fatal. One of the six had had the skin disease in 1891 and again in 1892, and one of them had had a slight attack in 1892; all the rest were attacked for the first time in 1893.

(C) Cases in the Fulham Union Infirmary, 1893.—By the courtesy of Dr. William Steer, the Medical Superintendent of that Infirmary, I am able to give particulars of three fatal cases of the disease that were under his care, aged respectively 56, 58, and 74. One arose in July and two in October, 1893.

William J., aged 58, was attacked in July with a general erythema, going on to an "eczematous" exudation, the epidermis separating in thin flakes. His temperature at first went up to 101.5°, but was subsequently normal. He had diarrhoea, loss of appetite, and intense weakness. The urine contained some albumin. He became delirious, and at the end of thirty days he died in a state of coma, in spite of the free administration of stimulants. A lotion of 1 in 4,000 perchloride of mercury was applied to the skin.

James W., 74, had, on October 7th, a papular rash. It first appeared on the trunk, and then spread over the whole body. It was followed by slight exudation and by profuse exfoliation of the cuticle. His temperature gradually rose, reaching 101° F. on the 12th. It remained high for a few days, and then fell to normal on the 22d. Delirium supervened, and, passing into a comatose condition, he died on October 31st.

Robert F. McK., aged 56, was attacked on October 19th with

“eczematous” patches all over the body. At first there was a good deal of exudation, but it soon became dry. There was profuse exfoliation. There was slight elevation of temperature, until the 23d, when it became normal and kept down until three days before death. Bronchitis then supervened, and the temperature rose to 100.5°. He finally became very drowsy, and died comatose on November 3d.

In all these cases the skin lesion was very severe. There was marked asthenia, and anorexia, the conjunctiva being also attacked. In all three patients the temperature was somewhat elevated at some period of the disease, and they all had albumin in the urine.

Dr. Steer believes that these were the only cases which arose in his Infirmary during the year 1893.

(D) Outbreak in the Bethnal Green Workhouse, 1893.—By the courtesy of Dr. John Knox, the Medical Officer of the Workhouse, I had several opportunities of seeing these cases, and he has been kind enough to supply me with the leading facts of the outbreak, as follows:

Eighty-six cases arose in the different wards (45 male, 41 female), between May 4 and June 10, 1893. Before and after these dates there were no cases; so it may be observed that the outbreak was severe in point of number of cases during the short time (five and a half weeks) that it lasted. The approximate number of persons exposed to contagion during that time was 836 (454 male and 382 female). Thus the attack rate was 4 per cent. Out of the 86 cases 5 died of the complaint (3 males, 2 females), giving a case mortality of 5.8. The most common starting points were the wrists and forearms. The eruption became universal in about one-fourth of the cases. The temperature was a little elevated in most of those cases where the skin was universally involved. The most marked constitutional symptoms were anorexia, vomiting and diarrhœa. The immediate cause of the fatal issue was bronchitis (1 case), asthenia (2 cases) and coma (2 cases). Most of those attacked were middle-aged or elderly persons, but there was one young subject, a girl, aged 14, who had the disease mildly. The average duration of attack was about two months. No internal treatment had any apparent effect, but soothing external applications relieved the irritation.

There is no doubt whatever that these cases corresponded precisely with the disease described by me in 1891, but the *average type of case was undoubtedly considerably milder.*



The average duration was about the same, but only one-fourth of the patients, as compared with one-half of mine, had a universal distribution of the rash. The attack rate was only 10 per cent., as compared with 19 per cent. The case mortality was only 6, as compared with 13 per cent. Thus, it will be seen that the proportion of cases with a general eruption, the proportion attacked, and the proportion of deaths, were practically half the similar figures in the series of cases under my care in 1891. It follows, therefore, that the Bethnal Green epidemic of 1893 was only half as severe as the Paddington epidemic of 1891.

*Section II.—Although the disease is undoubtedly, under some conditions, contagious<sup>1</sup> and epidemic, it nevertheless not infrequently occurs sporadically. Conditions under which the disease becomes epidemic.*

Sporadic Cases.—In the preceding section I have only made reference to the *epidemics* that have arisen since what might be called the Great Epidemic Year of 1891. But it is of the highest importance that note should be taken of the fact that the disease may occur sporadically, both as regards locality and the absence of pre-existing sources of infection.

In 1891<sup>2</sup> I referred to the fact that one out of the 163 patients at the Paddington Infirmary was brought in with the skin infection already upon him, but I have nowhere as yet given the history of that case.

W. B., aged 61, was residing in the western district of London, one-fourth of a mile or more distant from the Infirmary, when he developed the eruption, about June 18th, behind the ears. He was admitted to the Infirmary on June 20, 1891. In the course of a few days the eruption attacked the arms, the legs, the head, and afterward became universal. At first there was a good deal of exudation, but this was soon replaced by the characteristic desquamation of cuticle. He got better in seven or eight weeks, but the disease was followed by a relapse, complicated with severe conjunctivitis. He was well again at the end of thirteen weeks. Afterward his hair came out and he became nearly bald. The temperature in this case was, on several occasions, a little above normal (99° or 100° F.) but he did not suffer from weakness, vomiting or diarrhœa.

This patient lived, it will be observed, a considerable distance from the Infirmary, and I made at the time exhaustive

<sup>1</sup> Monograph, p. 31.

<sup>2</sup> Loc. cit., p. 6.

inquiries into any possible source of contagion, but without success. It seems a clear instance of sporadic origin.

In the early part of 1892 I received information of many sporadic cases, which were communicated to me by the kindness of my medical friends.<sup>1</sup> One of these cases, under the care of Dr. William Cock, is narrated in the *British Medical Journal* of January 9, 1892 (p. 68). Another case was shown by Mr. Turner at the Harveian Society on January 17, 1892.

Two of the 14 patients under treatment for the disease in the Paddington Infirmary in 1892 had first developed the rash while at their own homes, before coming to the Infirmary. Both of these cases had previously had the affection in 1891.

Reference is also made to a sporadic case under the care of Dr. Evans, in the *British Medical Journal* of January 9, 1892 (p. 56).

In the Autumn of 1892 I saw a lad, Charles P., aged 10 years, residing in the western part of London, a patient of Dr. Thorsly Jones, with whom I saw the case in consultation. He had been attacked by an eruption three weeks before. It had started in groups of red "pimples" on the thighs, first on the right, then on the left, with more or less symmetry. The skin a day or two later became "flaky," and the eruption spread to the other limbs and to certain places on the trunk; finally nearly all the body, excepting the back, became involved. The doctor informed me that the temperature had been up, during the first two days, to nearly 100°, but had been normal ever since. In the early stage the child had been sleepy and heavy, and suffered from loss of appetite, but he had not taken to bed. Since then the general health had been good. He had been up and about all the time, but did not go to school.

When I saw him there were still a few pimples dying away from the front of the thighs, and the skin was a little thickened in that situation. There was a scurfiness and desquamation of the skin everywhere, and the epidermis of the hands and feet was hard, parchment-like, and coming off in large flakes.

Careful inquiry failed to elicit the existence of any skin disease among his numerous brothers and sisters, friends of the family, playmates or schoolfellows. In this case the disease lasted altogether for about five weeks.

A day or two before I saw him, that is, about three weeks after the commencement of his illness a little brother aged five

<sup>1</sup> Monograph, p. 64.

had had a slight feeling of malaise, accompanied by a precisely similar eruption around the chin.

In November of 1892 I was consulted by a young woman aged 30 years, for boils. She gave me a clear history of having been attacked while in Paris about three months before with a red eruption, followed by very copious desquamation. When I saw her the skin showed precisely the scurfy appearance which occurs during recovery from the epidemic skin disease which I have described. Some of the cases in 1891 were followed by boils.

Conditions under which the disease becomes epidemic.—It would seem, from a study of all the cases that I have been able to see or find recorded, now nearly six hundred in number, that the disease is only contagious or epidemic under certain conditions. The three chief conditions upon which its contagiousness depends appear to be:

1. A predisposition in those exposed to the contagion by reason of advanced life, or of debilitated health: this has been dealt with fully elsewhere.

2. A collection of patients suffering from the disease in one place engendering, it would seem, a concentration of the poison. It certainly seemed to spread very rapidly under these conditions; and,

3. Certain obscure seasonal and meteorological conditions. Nearly all the known cases have arisen between May and November, during the Summer and Autumn months, and there is a marked tendency toward the spread of the disease at these times. This much is certain.

It is a fact of some importance that in 1891 there were 163 cases in the Paddington Infirmary and Workhouse, in 1892 14 cases, and in 1893 6 cases; and it might be thought that certain meteorological conditions of the first-named year had some causal relationship to the epidemic. But it should also be remembered that 86 cases arose within a very short time in the Bethnal Green Workhouse in the last-named year (1893), when there were so few at Paddington.

As regards other conditions necessary no very precise information is yet attainable. In view of the fact that the disease at Paddington in 1891 spread from ward to ward with great rapidity the distance necessary for infection need not, apparently, be very short; but, on the other hand, the free communication between these wards by means of doctors and nurses, for no isolation was attempted, would negative the value of this

observation. But, again, the rapidity with which the disease spread in the Bethnal Green Workhouse, where 86 persons were attacked in different parts of the building in the short space of five and a half weeks, and where isolation was in some measure enforced, would tend to show that this malady may be spread through some distance.

*(To be continued.)*

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PERSISTENT URETHRAL DISCHARGES DEPENDENT ON SUB-  
ACUTE OR CHRONIC SEMINAL VESICULITIS.

*(Concluded from page 243.)*

BY

EUGENE FULLER, M.D.,

New York.

**IX.** —Thirty-four years old; had gonorrhœa six years ago. Since that time he has never been free from a urethral discharge. During the early stages of the gonorrhœa he had a double epididymitis, which affection showed a great tendency for several years to relapse in connection with the left testicle. In search of relief this patient had visited many surgeons of reputation. All kinds of injections and applications, both anterior and deep, had been used; internal urethrotomy followed by large-sized sounds had been tried, all to no purpose. On examination I found the vesicles the real seat of his trouble. Both of them were very much distended and thickened. In answer to my questions I learned that although he could accomplish sexual intercourse, yet little pleasure was experienced, and the ejaculation was very feeble. I undertook the treatment of the vesicles in this case, without great expectations, and made no promises. As the result of six months' treatment the patient is decidedly better than he has been for a long time. His general feelings are better as well as his sensations experienced during coitus. His discharge has diminished, but has not disappeared. The vesicles to the feel are improved. They are not as distended, the walls are not as thickened, and the amount of fluid to be pressed out is considerably less. The patient desires a continuance of the treatment. The pathological condition of the vesicles in this case seems to resemble closely that of Case VIII.



X.—Thirty-six years old ; had gonorrhœa twelve years ago. Seven years ago being troubled with a relapsing discharge, he was treated by electrolysis. Since that time the relapsing discharge, although diminished in amount, and of less frequent recurrence, still persisted, associated with a perineal pain after erection. His erections although frequent always failed him on attempting coitus. In this case both vesicles, especially the left, were found distended and moderately thickened, no urethral disease being discovered. After a moderate amount of treatment all feelings of discomfort disappeared, and there being no more signs of discharge, the patient became irregular in attendance before thorough restoration in the vesicles had taken place. In the future this case may need some further treatment, though at present well, as far as subjective symptoms are concerned.

XI.—Twenty-two years old ; had gonorrhœa over two years ago. One year ago, being troubled by a thick glairy discharge which followed straining at stool or any sexual excitement, he sought relief at my hands. The left vesicle was found to be much distended. After six weeks' treatment some inflammatory symptoms resulting, partial suspension of the strippings for a month was deemed prudent, at the end of which time active treatment was resumed for two months. At that time the patient, being much improved in all respects, had to leave the city. Six months afterwards he reported, stating that he was well of all discharge, and had been so since shortly after leaving the city. Examination showed the condition of the vesicles to be satisfactory. There was, however, a suspicious hardness and unevenness to the feel of the prostate that made me suspect that later on tubercular evidences might manifest themselves.

XII.—Twenty-seven years old ; came seeking relief for a chronic urethral discharge which he had had for four years. This discharge had its beginning in a gonorrhœa which was complicated with an epididymitis in connection with both testicles. There was no pain and no disturbance of micturition in connection with the discharge, which was muco-purulent and very profuse, so much so, indeed, as frequently to saturate a handkerchief in a few hours. His sexual powers were very much weakened, though oftentimes the sensations were aggravated. He had no stricture. Anterior and deep injections besides large-sized sounds had been used without any benefit. In fact, he had come to the conclusion that all local treatment up to date had aggravated rather than relieved his condition. Examination of

the vesicles showed them both to be very flabby and distended. The walls were moderately thickened. The sacs were not tender to the feel. Pressure ejected a large amount of fluid, fully half an ounce running out of the penis. In this vesicular material there were a few dead spermatozoa, which showed that the double epididymitis had not succeeded in entirely blocking both spermatic cords. The prognosis of this case as the result of the first examination did not seem to me very favorable, owing to the lack of sensation in the vesicles and to their very distended condition, which seemed to indicate a great lack of muscular tone. At the end of five or six treatments this patient was called away on business, although at the time he felt that the treatment was improving his condition. About five months afterward I was informed by letter that the improvement following the strippings still persisted, and that as soon as business would allow he would report again for further treatment. I feel that the discharge in this case could be entirely cured by a continuance of the manipulations. Whether the tone of the vesicles could be wholly restored is somewhat doubtful; still, youth in this case is a very favorable feature, and if great regularity of life could be combined with it I think there might be a perfect recovery.

XIII.—Twenty-three years old; married a year ago; sought relief for a sticky discharge which kept the meatus at all times wet. He had never had gonorrhœa. He had noticed the discharge for some months, and recently there had been associated a dragging sensation in the testicles. His occupation was sedentary. There was a history of sexual excess since marriage. A short time previously a doctor had given him a deep urethral injection of nitrate of silver. This had apparently aggravated the existing symptoms. Examination showed the vesicles to be extremely tender and very moderately congested. A fair amount of gelatinous material was squeezed out. The first treatment gave much relief, and after four succeeding visits the patient was discharged cured. In this case tonics and proper directions concerning exercise and sexual moderation were most important in the after-treatment, otherwise a relapse might be expected.

XIV.—Thirty-eight years old; complained of a discharge from the urethra of six weeks' duration coming on ten days after exposure. The discharge had never been accompanied by painful sensations. In earlier life he had had gonorrhœa. Numerous injections were tried, and the discharge diminished. The anterior urethra being somewhat granular and moderately

strictured, sounds were used, and the strictures thoroughly dilated. As a result of this treatment the urethra appeared to be in a healthy condition. Still, the morning drop continued. The vesicles were then examined, though there were no special symptoms pointing in that direction, aside from the persistence of the discharge, and a history of considerable sexual indulgence. The sacs were found to be tender and slightly distended, but not thickened. As the result of stripping a fair amount of transparent gelatinous fluid was pressed out. A few strippings sufficed to dissipate all the remaining evidences of discharge. The patient now reports, ten months after the cessation of treatment, that he has continued perfectly well.

XV.—Twenty-seven years old ; had had numerous attacks of gonorrhœa. Three years ago, being troubled with difficult and frequent micturition associated with anterior and deep urethral inflammation, a strictured condition of the urethra was discovered, especially marked at the bulbo-membraneous junction. Anterior urethrotomy was performed, and the deeper stricture, which proved to be soft, was treated successfully by gradual dilation. By this treatment the patient was entirely relieved for a year and a half. At that time as the result of alcoholic and sexual excess, there apparently being no fresh contagion, a posterior urethritis associated with left-sided epididymitis, developed. After the testicle had fully recovered the posterior urethritis persisting, sounds and deep injections, which had proved themselves to be so efficacious formerly, were employed. At this time, however, instead of relieving the symptoms, they only served to aggravate them. On making an examination of the vesicles, the left one was found to be distended, infiltrated and very tender, much purulent material being squeezed out. All urethral treatment was suspended, and a few gentle vesicular strippings were given, followed by an improvement in the symptoms. Then all local treatment was suspended for six weeks, there being danger of stirring up an acute vesiculitis. At the end of this time examination showed such improvement to have taken place that nature was left to complete the cure, which she speedily did, aided by the observance of regular modes of life.

*Tubercular Involvement of the Vesicles.* XVI.—Twenty-seven years old ; had gonorrhœa followed for more than a year by a persistent discharge. The patient was tall, thin and strumous. He never took much exercise, and spent little time out of doors. Examination of the urethra showed it to be granular

and somewhat strictured. These conditions yielded to treatment, but a considerable mucous discharge still persisting, the vesicles were examined. These sacs were found to be slightly tender and somewhat thickened, a fair amount of fluid being squeezed out. After stripping the vesicles a few times the discharge stopped, and the patient disappeared satisfied with his condition. The feel of the vesicles, however, as the result of the few treatments, had not improved. In about three months the patient reappeared, stating that after free sexual indulgence the discharge had reappeared. The vesicles at this time, although not tender, were much more thickened than when first observed, the infiltration extending into the peri-vesicular tissues. The prostate also seemed firm and somewhat enlarged. The condition being considered tubercular no further local treatment was deemed advisable at the time, cod liver oil and hygienic measures being prescribed. A short time afterward the tubercular process extended to the left epididymitis, involving it in a characteristic manner. This patient when last seen was improving slowly under general treatment.

XVII.—Twenty-three years old; came complaining of a discharge due to a gonorrhœa which had persisted for a year and a half in spite of judicious measures directed toward the urethra. The urethra at that time being apparently sound, attention was directed toward the vesicles, the left one of which was found to be somewhat tender, infiltrated and distended. The patient was strumous and anæmic. Cod liver oil was prescribed and vesicular strippings attempted. After a few of these local treatments the discharge greatly diminished. As, however, the indurated condition of the vesicle seemed to be increasing it was thought best to stop all further local treatment, and to rely wholly on general anti-tubercular measures. As a result after a few months examination showed the discharge to have disappeared and the vesicle to be almost normal to the feel, a little thickening only persisting.

XVIII.—Thirty years old; sought treatment for a urethral discharge which had resisted various applications and injections. He had previously had gonorrhœa. The exact cause of the present discharge was not from his history clear. He was tubercular in appearance and had had trouble with one lung. The urine contained some free pus. The discharge was evidently more in connection with the posterior than the anterior urethra. The vesicles were found to be distended and somewhat thickened, considerable fluid being pressed out. A few very



gentle strippings served to stop the discharge and to improve his local sensations without adding to the inflammatory infiltration of the part, which was evidently tubercular. Since then the patient has married and his general health seems to be improving. There are at present no local symptoms.

XIX.—Thirty years old ; sought treatment for a slight urethral discharge and frequent seminal emissions. He was tall and thin. Had had lung trouble, for which he had gone to Colorado, where he had improved, although since coming East again he had lost flesh quite rapidly and felt generally weak. He had never had gonorrhœa. Examination of the vesicles showed them to be somewhat thickened and a little distended. A few gentle strippings served to relieve his symptoms. The vesicles, however, becoming more tender and seeming to resent the manipulations, the patient was sent to the Adirondacks, where he continued to improve.

XX.—Thirty-three years old ; came for a slight discharge appearing three days after excessive intercourse. Had had gonorrhœa several years before. The present trouble was chiefly confined to the deep urethra, and was evidently not a fresh infection. The vesicles were examined and seemed normal. The patient was thin and anæmic, with a tubercular history. A few light deep injections were given. The deep urethra was very tender, and the injections, instead of proving beneficial, served only to aggravate matters, and that form of treatment was abandoned, internal remedies alone being relied on. After a few weeks' interval the vesicles and prostate, on further examination, were found to be lumpy and infiltrated, though not especially tender. Cod liver oil, together with hygienic measures, were now prescribed, all further attempts at local treatment being abandoned. The patient then began steadily to improve and in two months the prostatic and most of the vesicular induration had disappeared, a slight serous discharge persisting. The patient is now in the South, with good prospects of recovery.

XXI.—Forty-two years old ; came with a profuse purulent discharge. This was his third attack. He had been treated by injections and was getting worse. There was much frequency in urination, associated with pain. He had chordee. In early life he had had tubercular hip joint disease with extensive suppuration. Rectal examination showed the vesicles, especially the right, to be much inflamed and infiltrated, a considerable amount of bloody vesicular fluid being pressed out. Shortly

afterward the inflammation extending, the right epididymis became acutely inflamed, suppuration finally resulting. During this acute attack the patient was put to bed and general palliative treatment employed. By the time the epididymis had been drained and cured the discharge from the urethra had disappeared and the urine had become clear. Examination of the vesicles at this time also showed resolution in that quarter.

XXII.—Thirty-four years old; came for a discharge two months old, which appeared directly after an excess of champagne and sexual intercourse. He had had gonorrhœa years before. His urethra had been examined for stricture with negative results. His present discharge had not until recently caused him any pain or inconvenience aside from its presence. Shortly before coming for consultation he had made a trial of sexual intercourse. The act had caused him considerable pain and had aggravated his condition. He had received no benefit from injections. Rectal examination showed both the vesicles to be inflamed, nodular, and somewhat distended. A few gentle trials of vesicular strippings were made, but had to be abandoned as the parts became more nodular and infiltrated. Whiskey in stated amounts and cod liver oil were then prescribed, together with hygienic measures, all local treatment being stopped. The patient, who before had been anæmic and somewhat wasted, speedily improved, both locally and generally. Now, at the end of three months, the vesicles although a little distended, have lost their nodular infiltrated feel and the discharge, which persists very moderately, has no longer its purulent characteristics, but has become watery.

It is quite possible that readers of this article after considering the cases reported, in which the urethral discharge was seemingly dependent on the associated vesiculitis, may infer that such a discharge is one of the cardinal symptoms to be looked for in diagnosing this disease. This idea is to be discouraged, not only because it is very inaccurate, since in a great many cases of vesiculitis there is no discharge, but also because it might lead those who are inclined to be superficial and to jump at conclusions to neglect the study of the urethra, the common seat of the lesion causing a discharge, together with other possible sources. We have all seen illustrated this tendency to jump at conclusions in this same matter of persistent urethral discharges as the result of Dr. Otis's writings on stricture of large calibre. These ideas, good in themselves, and valuable in the right place, were so perverted that it became

the routine practice with many to cut freely the anterior urethra, not only in all cases where there was a chronic discharge, but also oftentimes even for pus in the urine, no attempt apparently having been made to trace the source of the pus, which in a number of cases I have in mind was of pelvic origin.

I wish also to impress on the professional mind the frequency of tubercular inflammation of the vesicles, and to warn all in these cases to exercise the greatest care in attempting digital rectal treatment, lest the condition of the patient be aggravated rather than palliated. The practiced finger will soon learn to detect this condition either at the first examination or very shortly after commencing a course of strippings as the result of the inflammatory reaction produced by the manipulations.

The following conclusions are drawn :

1st. Seminal vesiculitis is the cause of chronic urethral discharges in a certain percentage of cases.

2d. In about one-third of these cases the seminal vesiculitis is tubercular in character.

3d. It is most important to differentiate between the simple inflammatory and the tubercular cases, owing to the difference in prognosis and treatment.

4th. In the simple inflammatory cases the prognosis is good unless the subject is of an advanced age, the duration of the treatment depending largely on the chronicity of the case.

5th. The treatment employed in these simple cases consists of stripping the vesicles, thereby squeezing out into the urethra their inflammatory contents by means of the fore-finger introduced into the rectum. This treatment should be employed once in five to seven days, a long interval being allowed to elapse between treatments should signs of acute inflammation appear as a result of the manipulations.

6th. The duration of the treatment may be all the way from a month or six weeks in subacute cases to many months and possibly a year in very chronic ones.

7th. At the commencement of treatment the parts are usually very tender, indurated and distended. If the case progresses favorably all these elements gradually diminish and finally disappear as resolution takes place. The discharge customarily wholly disappears before a cure in the vesicles is attained.

8th. In tubercular cases the tenderness in connection with

the vesicles is not liable to be so great as, and the induration more than, in simple inflammations. In this form of inflammation the parts resent the manipulations, unless, indeed, they be most gentle, and even then it is a question if this form of treatment is beneficial. If the tubercular condition is not diagnosed at first the manner in which the vesicles, when so involved, resent the ordinary manipulations by becoming more tender and indurated, thus aggravating the urethral symptoms, speedily renders the correct diagnosis apparent.

9th. Many of these tubercular cases become quiescent under internal medication and hygienic measures.

109 East Thirty-fourth Street, New York.

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## Society Transactions.

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### AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

EIGHTH ANNUAL MEETING, HELD AT WASHINGTON, D. C., MAY 29, 30, 31 AND JUNE 1, 1894.

DR. GEORGE CHISMORE, *President, in the Chair.*

**Modifications of Bigelow's Operation for Stone in the Bladder. Designed to Meet Cases in which the Prostate is Enlarged.**<sup>1</sup>—DR. GEORGE CHISMORE, of San Francisco.

DR. L. BOLTON BANGS, of New York, said he was much interested in Dr. Chismore's paper, particularly in that part which referred to performing the operation for stone under local anæsthesia. The class of patients in whom this operation is called for are especially susceptible to the secondary bad effects of general anæsthesia, which is apt to produce congestion of or even actual inflammatory changes in the kidneys. The results obtained by Dr. Chismore are certainly very satisfactory.

DR. FRANCIS S. WATSON, of Boston, said that were it not for the fact that Dr Chismore, in his paper, presented such a strong array of figures he would feel inclined to regard the method of operation recommended by him as a distinctly retrograde one. The Bigelow operation has its chief value in the fact that none of the fragments are left behind, and the high mortality following lithotripsy in former times was due, in all probability, to the presence of such fragments. He did not see why this should not be so in Dr. Chismore's cases, where a large fragment was often left in the bladder. Still, the proof of the pudding is in the eating, and the statistics presented by the author of the paper speak for themselves. In cases where the hypertrophied prostate offers serious difficulty to the passage of the evacuating tube through the deep urethra, Dr. Watson said he is in favor of per-

<sup>1</sup> Will be published.



forming the operation recommended by Mr. Reginald Harrison, and by others before him, which consists in making a perineal incision, dilating the deep urethra, and then rapidly crushing and evacuating through the opening thus afforded. By this procedure we obviate the danger of injuring the deep urethra : death in old men is usually due to injury to this part of the canal.

DR. W. K. OTIS, of New York, said that in many of these cases, where the stone is hard, it is difficult to get an instrument into the bladder which is sufficiently large to crush it. In cases where the prostatic enlargement is considerable he felt inclined to favor the supra-pubic operation for the reason that it enables one to entirely empty the bladder of stone ; furthermore, the prostate itself can be operated on at the same time, if it is deemed advisable, and the bladder drained. The results obtained by Dr. Chismore, however, are so satisfactory that the method recommended by him is well worthy of a trial, especially in those patients who object to any cutting operation.

DR. JOHN P. BRYSON, of St. Louis, said he had never met with much success in his attempts to increase the calibre of the prostatic urethra by the introduction of sounds, owing to the amount of irritation produced. Local anæsthesia, in operations on the bladder, has certainly great advantages over general anæsthesia, either with chloroform or ether. Dr. Bryson said he was fully in accord with the statement made by Dr. Watson regarding the bad effects that are apt to follow instrumental manipulation of the prostatic urethra in these cases. In the class of cases which mainly come under his observation, namely, those in which the stone formation is secondary to bladder inflammation, associated with a certain amount of inflammation of the prostate, he considered it advisable to drain the bladder after the calculus has been removed. If necessary, prostatectomy can be performed at the same time. A fragment of stone left behind is not apt to do as much damage in these cases where the bladder is large and there is always more or less residual urine, as it is in young persons, where these conditions do not exist.

DR. JAMES BELL, of Montreal, said that if local anæsthesia answers the purpose in these cases it renders the operation for stone much less formidable. He was surprised to learn that Dr. Chismore was in the habit of injecting such large amounts of cocaine into the bladder without producing dangerous results. In his own practice he is in the habit of performing supra-pubic section in these cases, and then draining the bladder ; this, of course, can only be done under general anæsthesia.

DR. EDWARD MARTIN, of Philadelphia, said that in view of the fact that chloroform has lately been shown to be even more irritating on the kidneys than ether the employment of local anæsthesia in these cases is of great practical importance. Dr. Chismore's statistics certainly speak for themselves. Personally, he has often found it a difficult matter to pass a solid or even a soft instrument through the urethra in these cases, and theoretically the procedure of crushing the stone through a perineal opening seems easier.

DR. F. TILDEN BROWN, of New York, inquired whether Dr. Chismore had observed symptoms of cocaine poisoning in any of his cases ? The amount of the drug injected was certainly very large.

DR. SAMUEL ALEXANDER, of New York, said that in cases with enlarged

prostate and thickening and hypertrophy of the bladder and excessive irritability of that organ, it appeared to him that the partial removal of a stone and the leaving behind of a fragment would be exceedingly disagreeable, if not dangerous. He did not see how such patients could be operated on at the surgeon's office, and then allowed to return home.

DR. WILLIAM JUDKINS, of Cincinnati, said he was chiefly interested in the question of local anæsthesia by means of cocaine. He has employed the drug in much smaller quantities, and in some instances quite alarming results have followed.

DR. L. BOLTON BANGS, of New York, said it is difficult to decide in some cases which operation will be the best one for his patient. By the suprapubic method the bladder can be best drained, and that operation is certainly indicated in some instances; in others, some modified form of the perineal operation is better. In seven cases coming under his observation he has performed a modification of the so-called Dolbeau operation, by making a perineal incision, and then stretching the prostatic urethra so as to gain ready access to the bladder. As regards the employment of local anæsthesia in this region, Dr. Bangs said he has always found it a difficult matter to cocainize the deep urethra; it is easy to introduce the cocaine solution into the bladder, but it will not remain in the prostatic urethra long, enough to produce anæsthetic effects. He has found that it takes about six minutes to anæsthetize the urethra.

DR. CHISMORE then closed the discussion. He stated that in June, 1889 he employed general anæsthesia for the last time in operating for stone. Since then he has invariably used local cocaine anæsthesia. In a small proportion of these cases mild toxic symptoms, such as nervousness, restlessness and perspiration were observed; these were never very pronounced—certainly not sufficiently so to induce him to suspend the operation, or discard the use of the drug. In some cases he has employed eight ounces of a four per cent. solution; in others a much lesser quantity. About an ounce or an ounce and a half of the solution is injected into the deep urethra and allowed to flow back into the bladder. The prostatic urethra is thus cocainized by simple contact. After the injection has been allowed to remain in the bladder for a few minutes the lithotrite is introduced, and as much of the stone is crushed as possible. If he wishes to increase the dimensions of the bladder he injects a solution of boric acid.

In these cases with prostatic enlargement the bladder is far more tolerant than in young persons, and a fragment of stone left behind does not give rise to much inconvenience. It is certainly better to leave it there than to make a prolonged search for it. Dr. Chismore said he quite agreed with Dr. Watson that in injuries to the deep urethra we must look for the principal source of danger in almost all operations which involve a manipulation of this part of the canal. To avoid inflicting such injury he now employs a much smaller lithotrite than formerly. In many patients whose catheter life has been of some duration, narrowings of the urethra, or "catheter strictures," as they might be called, are often met with: they usually exist in the pendulous urethra, about two inches from the meatus. When these are dilated, an instrument often passes into the bladder with comparative ease.

Dr. Chismore said that a study of these cases seems to show that a patient is no safer from recurrence of stone after supra-pubic cystotomy

than he is after litholapaxy, and the latter is certainly by far the simpler and easier of the two operations. As regards the perineal incision referred to by Dr. Watson, and advocated by Reginald Harrison and others, we must not lose sight of the fact (which was first brought out by Dr. Watson himself) that in these cases the perineal distances are very much increased and we may utterly fail to reach the stone after making an opening in this region.

**A Summary of the History and Present Position of the Operation of Castration for Hypertrophy of the Prostate.**—DR. J. WILLIAM WHITE, of Philadelphia. The author stated that a series of experiments on dogs had been made under his direction with the view of determining whether or not castration would be followed by notable atrophy of the prostate. The idea that this was possible was suggested to him by the comparison long ago made by Valpeau, and afterward by Sir Henry Thompson, between prostatic and uterine fibro-myomata. In these experiments the first castration was done January 27, 1893; the others followed at intervals of a few days and the results, showing rapid atrophy, first of the gland and then of the muscular elements, were very decisive. The line of argument, theoretically, is as follows: The prostate, while not embryologically the true homologue of the uterus, is developed from structures quite distinct from those which form the urinary passages. The structure of the prostate and of the uterus is strikingly similar. Its growth is in direct relation to the sexual life of the individual; its over-growth occurs at a period when the sexual life is fading out, but is usually not extinct.

The reproductive powers of life end sooner in the female than in the male; accordingly we find fibro-myomata appearing earlier in the former than in the latter. The histology of the growths are markedly alike in the two sexes. The uterine tumors do not appear after the menopause, or, if present already, undergo atrophy. After a certain period of life there is no increase in the tendency to enlargement of the prostate, but rather the reverse. In the female oöphorectomy causes the disappearance of these growths and atrophy of the uterus itself. Castration almost certainly has the same effect upon the normal prostate.

The fact that we have no examples of spontaneous shrinkage of the hypertrophied prostate in old age may be explained by the great frequency with which the trouble causes death in such cases. Messer's and Desnos' observations go to show that after a certain period of life the frequency of notable hypertrophy diminishes and they suggest the possibility that in many cases physiological atrophy had already begun. Uncertainty as to the exact duration of the sexual life in the male also weakens the force of the statement that the condition does not manifest itself until after the period of life when it should occur if it were truly homologous with the uterine growth. In addition it may be said that there is accumulated evidence that prostatic hypertrophy begins much more frequently than was formerly supposed during middle life.

DR. WHITE then referred to a number of cases reported by Dr. Francis L. Haynes, of Los Angeles, Cal., who has three times performed double castration in old men afflicted with prostatic hypertrophy. In all these cases the operation was followed by very satisfactory results. He also referred to a case reported by Dr. F. Fremont Smith, of St. Augustine, Florida; this case was an almost hopeless one of prostatic hypertrophy, with

marked sepsis, cystitis, beginning uræmia, etc.; double castration was performed, and within fifteen weeks after the operation the patient gained 45 pounds in weight and has no further symptoms of cystitis or other urinary trouble.

On January 1, 1894, Dr. White operated on a man aged 69 who had a very large prostate, one-half the size of an orange. He had passed no urine excepting by the catheter for years. His urine was loaded with mucous and extremely offensive, and at intervals it contained blood. Double castration was performed, and at the present time, about four months after the operation, while the patient does not urinate spontaneously, rectal examination shows a reduction of the prostate to about its normal dimensions. The catheter, which it was formerly necessary to introduce nine and one-half inches before reaching the bladder, now goes in only about eight inches when the urine begins to flow. Its introduction is easy and painless. No blood has appeared in the urine for two months. The urine itself is entirely normal in every respect. In conclusion, the author said that the above and other cases that have been reported certainly established the claim of the operation to further and more extended trial, and show that even on the basis of experiment and theory alone he was justified in suggesting it to the profession.

DR. BANGS said he was very much interested in Dr. White's presentation of this subject. Any means whatsoever which promise some relief to this class of cases is certainly worthy of attention. In Dr. Smith's case, which was recently reported before the Genito-Urinary Section of the New York Academy of Medicine, there seems to have been no effort made to drain the bladder. In the vast majority of cases, complicated by cystitis, long-continued drainage of the bladder will achieve results equal to those obtained by castration in the case reported. In a case recently under his observation he felt strongly tempted to try this experiment. There was prostatic hypertrophy with cystitis and frequent and painful urination. After six weeks' drainage of the bladder the symptoms have greatly improved, the painfulness and frequency of micturition have disappeared, and there is a certain amount of spontaneous urination. If this enlargement of the prostate is dependent on the activity of the testes why not ligate the vessels of the latter organs instead of performing castration?

DR. BRYSON stated that frequent nocturnal urination is a marked clinical feature in prostatic hypertrophy, and it would be interesting to note whether this is the first symptom to disappear when improvement takes place in the size of the organ. To sever the vas deferens, as has been suggested by some as a substitute for castration, he thought would prove a useless measure. In one case of prostatic hypertrophy with very distressing symptoms coming under his observation, double castration was performed owing to the fact that both glands were involved by tubercular disease. Their removal was followed by a distinct improvement in the man's symptoms, and there was a marked diminution in his frequency of urination, especially at night. The experiment proposed by Dr. White in these cases is certainly worthy of trial. The difficulty probably is to obtain the patient's consent to the operation.

DR. BELFIELD, of Chicago, said the matter resolves itself into two questions, first, whether castration will produce the good results claimed for it ;



second, if so, whether it will take its rank among other operations for that end.

It has long been known that castration will produce atrophy of the normal prostate. The speaker said he now has under his care a man 23 years old in whom both testes were destroyed by tubercular disease. In that patient the prostate, within two years afterward, dwindled away to a mere nodule. While the idea that double castration is followed by atrophy of the normal prostate did not originate with Dr. White, he deserves credit for calling attention to the fact that the operation may induce a cure in hypertrophy of the prostate. We must bear in mind, however, that in the enlarged prostate we have certain elements or conditions that are not found in the normal prostate, namely: the growth of fibrous and adenomatous tissue, or a mixture of both, and it is a question whether these elements are affected by a cessation of the sexual activity of the individual. The removal of the ovaries cannot be relied upon in all cases to influence the condition of uterine fibroids. Many of the symptoms seen in patients with prostatic hypertrophy are due not so much to the actual enlargement of the organ as to the sequences that arise, such as inflammatory conditions of the prostate or bladder, and granting that double castration will secure atrophy of the normal or abnormal prostate, the question remains whether it will also produce a subsidence of the more aggravated symptoms. This can only be decided by actual clinical experience.

DR. WATSON said that he has had two cases which bear partially upon this question. In two patients, aged respectively 60 and 66 years, atrophy of the prostate on one side was produced by destruction of the corresponding testis, due to suppuration. In both of these cases the prostate had been enlarged for years, and the atrophy was a true retrogressive process.

DR. EDWARD MARTIN, of Philadelphia, said he saw the patient upon whom Dr. White had operated, before and after the operation, and there was a truly remarkable change produced in the size of the gland. Previous to the operation it was perhaps one-half the size of an orange, and resembled in all respects the typical enlarged prostate. Since the operation it has become normal in size.

DR. ALEXANDER W. STEIN, of New York, said that from a physiological standpoint Dr. White's paper was very interesting. We know, however, that the bladder in these cases is not relieved by simply removing the mechanical obstruction at the neck. The cystitis is often a parenchymatous inflammation, and the bladder becomes insensitive and is entirely unable to empty itself.

DR. BELFIELD said that if arrest of the sexual life will produce an actual cure of the troubles incident to prostatic hypertrophy, that end can perhaps be attained without the mutilation of actual castration, by producing atrophy of the testes. The question is how this can best be done. The excision of pieces of the vas deferens in a number of cases has not produced any apparent effect on the testis. The ligation of the spermatic artery often results in necrosis of the testis, so that actual castration would be better.

DR. SAMUEL ALEXANDER, of New York, said he has recently seen three cases of double undescended testes in which the organs were removed and were found to be atrophied. The vasa deferentia were examined and no spermatozoa found in them, nor were any healthy spermatozoa found in the testes themselves. In two of the cases the testes were fibrous. In all of

these cases a rectal examination failed to reveal that the prostate was diminished in size.

DR. BELFIELD said he has seen two cases of unilateral undescended testis with pronounced atrophy, and atrophy of the prostate of that side.

DR. BANGS said that he thought that the sexual appetite is not determined by the presence or absence of the testes in the scrotum. In one case of double cryptorchidism that has been reported the man had full sexual powers and was convicted of bastardy. By interference with the circulation of the testes atrophy may be produced.

DR. BRYSON said that mere cryptorchidism is, of course, a very different thing from anorchism. The testes may be concealed and yet have that nervous connection which will maintain their virility ; that is, their connection with the cerebro-spinal system.

DR. WHITE then closed the discussion. He stated that when he saw the patient who had been operated on by Dr. Smith the man was a mere skeleton, in the last stages of toxæmia, and in that case he did not think drainage could have been employed with any prospect of success, nor could he recall any case in which drainage alone has given results comparable to those obtained by the removal of the testes. The man was literally snatched from the very brink of the grave. Tying the vessels of the testis is apt to be followed by necrosis of the organ, and is therefore not to be recommended. This operation is, of course, still in embryo. What we want to do is to get a sufficiently large number of cases together to allow us to draw conclusions. If we find that castration will produce atrophy of the hypertrophied prostate there is no reason why it should not become a very widespread operation. In Dr. Alexander's case probably some small portion of the testes still retained its activity, in spite of the fact that the microscope failed to reveal the presence of spermatozoa.

**Suggestion as to the Best Method of Removing Fibro-Adenomatous Growths from the Prostate.**<sup>1</sup>—By DR. SAMUEL ALEXANDER, of New York.

DR. WATSON said that the operation of enucleation in reducing the size of an enlarged prostate is an important advance over the older method of biting or chewing off the projecting masses. It would be interesting to know in what proportion of these cases enucleation is possible. The combined operation, making an incision in the perineum and above the pubes, as devised by Dr. Belfield, has decided advantages. The method of checking hæmorrhage by means of a pad drawn down into the wound, as devised by Dr. Keyes, he has found very serviceable. Dr. Watson said he still employs the Peterson bag in these operations, for the purpose of pushing the bladder firmly against the abdominal wall.

DR. BELFIELD said that Dr. Alexander has carried the enucleation process to a much greater and more successful issue than any who have preceded him. He has also been more systematic in removing the mucous membrane so as to make enucleation possible. In most of the operations of this character that have been performed before the mucous membrane was merely split. The speaker said he wished to suggest another way to get at the prostate, namely, to separate the rectum from the prostate by making an incision into the ischio-rectal fossa, and then incising the neck

<sup>1</sup> Will be published.

of the bladder. By this means, he thought, it would be easier to enucleate the prostate than through a perineal opening. He has not employed the Peterson bag for a number of years. By means of the Trendelenburg position ready access to the bladder is obtainable.

DR. WHITE said that in all these discussions about operations on the prostate no mention is made of how little we may take away from the gland with resulting benefit to the patient. There seems to be a direct ratio between the amount of gland tissue removed and the death rate. The greater mortality is due to the increased danger of sepsis, hæmorrhage, etc. In one case he removed large masses of the prostate and the patient died a few days afterward of anuria. In another case he only removed a small portion at the neck of the bladder and the man improved rapidly, so far as his vesical symptoms were concerned. In these cases the important thing to do is to restore the urinary level at the neck of the bladder, and this can often be achieved by the removal of a very small amount of prostatic tissue.

DR. WATSON said that in one case he removed a small portion of the gland with the ecraseur with very good results.

DR. BELFIELD stated that in one case he took off a small lobe with a galvano-cautery with good success.

DR. BRYSON stated that in only one of his cases of prostatectomy has he seen really dangerous hæmorrhage, and in that instance the growth was adenomatous and probably malignant. He has noticed on several occasions that the source of the severe bleeding is the mucous membrane and the submucosa. Simply touching the mucous membrane may excite hæmorrhage in some cases. The speaker said that in his operations he is gradually removing more and more of the prostatic substance, and he is unable to answer Dr. White's question as to the relation between the mortality and the amount of tissue removed. If the operative work is rapid and the hæmorrhage moderate, he did not see how the amount of tissue removed could materially affect the mortality. He still employs the Peterson bag and has never performed a prostatectomy without it. Excepting in one case he has never seen the bag produce any considerable amount of rectal irritation. His practice is to introduce the bag and inflate it before distending the bladder with water; for the latter purpose he employs a hand-bulb syringe. He never injects more than eight ounces of water into the rectal bag.

DR. JAMES BELL, of Montreal, said that in his experience the fatal results after prostatectomy seemed to be due to some form of toxæmia, rather than to hæmorrhage during the operation. The patients did well for some days or weeks, and then died of toxæmia. In one case where he removed only a very small portion of the prostate the toxæmic symptoms were very pronounced. This fact led him to think that the probable source of danger is the exposure of the raw surface to the urine, and the development of the toxic substances.

THE PRESIDENT said he regarded the suggestion of enucleation in these cases as a very valuable one. He is not in the habit of inflating either the rectum or the bladder in operations of this character.

DR. ALEXANDER then closed the discussion. He stated that he makes the opening above the pubes so as to allow him to press down the prostate on the finger which is in the perineal wound. If hæmorrhage occurs he introduces the catheter into the bladder through the perineum and packs

underneath the mucous membrane, enlarging the wound if necessary. In his opinion, the mortality rate bears little or no relation to the amount of prostatic tissue removed: of more importance in this respect is the condition of the kidneys and the upper urinary tract.

**Report of Some Cases of Rupture of the Urethra.**—By DR. FRANCIS S. WATSON, of Boston.

The first case reported was as follows: Male; sailor; fifteen days before coming under observation his penis was struck by the handle of a wedge, rupturing the urethra midway between the meatus and the peno-scrotal angle. The integument externally was not ruptured. On first attempting to urinate a small amount of water passed through the meatus. Subsequent to this he was unable to pass any urine, which collected underneath the skin, forming an artificial bladder. A few days after the accident inflammation set in, with perforation of the distended sac, and the urine made its exit through two openings to the right of the symphysis above Poupart's ligament. In this condition he came to the hospital. Dr. Watson said the operation he performed consisted in draining the artificial bladder and performing perineal section, in order to avoid contact of the urine with the injured urethra. The urethra was then cut down upon and repaired. The man made a good recovery and at the present time a No. 29 sound can be passed into the bladder.

Four other cases of rupture of the urethra were reported by the author; in all of these the injury was received during coitus. In one of them the accident was followed in a few days by extensive infiltration of urine and gangrene of the entire skin of the penis. Skin-grafting by Thiersch's method was employed and a very good result obtained.

**Remarks on the treatment of Cystitis.**<sup>1</sup>—By DR. GARDNER W. ALLEN, of Boston.

DR. BRANSFORD LEWIS, of St. Louis, said he did not quite understand what distinction Dr. Allen made in his paper between inflammation of the posterior urethra and of the bladder itself. He also has found that in certain cases one medicated solution is indicated and in others another. We cannot depend upon any particular one. In some instances the benefit from the use of these various remedies is not observed until after they have been discontinued; during the time of their application there may be no improvement at all.

DR. WATSON said the author of the paper made the statement that a certain number of cases of cystitis have their origin in sexual excesses. He has never met with such instances.

DR. J. WILLIAM WHITE said he has never seen any case originate from this cause.

DR. MARTIN stated that the new antiseptic remedy, tricresol, promises to be very useful in this class of cases. It is a powerful antiseptic and causes very slight irritation.

DR. BRYSON said he had never seen a case of cystitis or posterior urethritis brought about by sexual excesses.

DR. ALLEN in closing the discussion said that in two cases coming under his observation in which the chief symptoms were painful and fre-

<sup>1</sup> Will be published.



quent micturition one of the patients gave a history of sexual excesses and masturbation, and the other prolonged continence ; no other reason for the trouble could be assigned.

(*To be continued.*)

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## THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY. STATED MEETING, TUESDAY  
EVENING, MAY 8, 1894.

DR. L. BOLTON BANGS, *Chairman.*

**Some Common Mistakes in the Treatment of Syphilis.**—(*Continuation of discussion on DR. FOX's paper.*)

DR. H. G. KLOTZ said he could not agree with DR. FOX's statement that all cases of aggravated syphilis depend on the causes he mentioned. Very aggravated cases may occur in strong, healthy individuals, and again there are strumous individuals in whom the disease runs a mild course. DR. FOX denies the truth of the experience of others that the tertiary symptoms more frequently develop in those cases wherein the early treatment was neglected. DR. Klotz said he believes that syphilis of the brain, cord, etc., usually affects those patients who had mild early symptoms, and who were insufficiently treated. The best possible treatment of syphilis is to keep all the organs in good condition, and for this purpose no remedies are equal to mercury and potassium iodide.

DR. R. W. TAYLOR said his views regarding the treatment of syphilis are so well known that he would not take the time to repeat them. Suffice to say that in almost every particular he disagreed with the statements contained in DR. FOX's paper.

DR. VAUGHAN said he was fully in accord with many of the statements made by DR. FOX. In many cases it is impossible to induce syphilitic patients to undergo prolonged treatment, and he has noticed that such patients do about as well as those who continue the treatment for two years or longer.

DR. FOX then closed the discussion. He stated that many of the arguments held out regarding the late lesions of syphilis are based on pure assumption. We are not in a position to say positively that cases of syphilis which go untreated or which are treated for only a short time develop brain and cord lesions, etc. Some years ago, at the New York Dispensary, he found that many of the syphilitic patients objected to taking mercury. They were put on a simple tonic and watched closely for some years ; they did about as well as those who were taking specific remedies, although perhaps their symptoms were not dispelled quite as quickly. They have now been lost sight of, and it is impossible to say whether they will die of syphilis or develop any late lesions. Late manifestations do occur, and the worst cases of this kind that he has ever seen were in patients who underwent thorough and prolonged treatment with mercury. He was fully in accord with the other speakers that mercury and potassium iodide—with time, are the three great remedies in the cure of syphilis. Brain tumors, locomotor ataxia, etc., are often attributed to syphilis. Probably no neur-

ologist will claim that there is anything about the lesions of locomotor ataxia that proves them to be syphilitic in their origin. If such a patient gives a history of chancre, or chancreoid, or gonorrhœa, or if the physician even gets a semblance of such a history, he assumes that the lesions are syphilitic. If they disappear under the administration of potassium iodide he thinks that proves his assumption. We know that many chronic diseases are favorably affected by specific remedies. Leprosy and other chronic skin diseases are sometimes relieved or even cured by mixed treatment. Dr. Fox said that so far as his experience goes he has noticed that the men who believe that syphilis should be vigorously treated with large doses of mercury are the ones who usually meet with these rare complications of the disease, and he is inclined to believe that they are sometimes the result of the treatment rather than of the disease. Years ago, when mercury was given in such doses that its curative effects were measured by the quantity of saliva that flowed from the mouth, syphilis was a much worse disease than it is to-day. It is claimed that the type of the disease has changed and that it is milder; perhaps its more benign character is due to a change in the treatment rather than in the disease.

**A Case Showing the Result of Castration for Tubercular Epididymitis.**  
—Presented by DR. C. L. GIBSON.

The patient was a man aged 84 years. When he entered St. Luke's Hospital in August, 1891, he had a small hydrocele on the left side, which originated about nine days previously from a traumatism. Otherwise he was in good health. The hydrocele was tapped and about an ounce of fluid was evacuated. The epididymis was found to be swollen, nodular and somewhat sensitive. A rectal examination proved negative. The patient had a daily rise of temperature and the left epididymis gradually became more sensitive. After several weeks' observation it was decided that he was suffering from an acute tubercular epididymitis, and castration was performed on September 4, 1891. The man made a good recovery and left the hospital eleven days after the operation. He has since remained in excellent health. The pathological report confirmed the diagnosis of tubercular epididymitis.

**A Mixed Malignant Growth of the Testicle.**<sup>1</sup>—Exhibited by DR. R. W. TAYLOR.

DR. E. L. KEYES said that a few cases have come under his observation in which a growth in this region was made up of heterogeneous elements—fibroma, sarcoma, etc.—and in each instance a recurrence of the malignant growth appeared in the retro-peritoneal glands, not in the groin.

**A Case for Diagnosis.**—Presented by DR. H. GOLDENBERG.

The patient was a boy aged 15 years, who had a large swelling occupying the left half of the scrotum. It was soft to the touch and divided into three or four sacs. The swelling has existed for four years and gives rise to no inconvenience. It is transparent and fluctuates on palpation. The contents of the cyst cannot be removed, either partially or wholly, by pressure or position; there is no impulse on coughing. Dr. Goldenberg said he re-

<sup>1</sup> Will be published.

garded the case as one of multilocular hydrocele of the spermatic cord, although there is a possibility of its being a case of hydrocele into a hernial sac.

DR. TAYLOR said he regarded the case as one of multilocular hydrocele of the cord.

DR. EUGENE FULLER said he agreed with Dr. Taylor. If it was a case of hydrocele connected with a hernial sac it would be a single cyst, not multilocular.

DR. SAMUEL ALEXANDER said that from the condition of the internal ring he did not think the boy ever had a hernia. He agreed with Drs. Taylor and Fuller.

DR. KEYES said he also regarded the case as one of multilocular hydrocele of the cord.

#### A Case for Diagnosis.—Presented by DR. R. GUITERAS.

The patient was a man aged 51 years. About eight years ago he first noticed a slight enlargement of the left testicle. Its condition remained unchanged for five years, when it again began to enlarge until it reached its present size. It has not grown any larger during the past three or four months. There is no history of specific, tubercular or malignant disease. There is no pain associated with the growth.

DR. C. W. ALLEN regarded the case as one of syphilis. Epididymitis of this type, he said, may occur late in the course of syphilis. He advised large doses of potassium iodide and local mercurial inunctions.

DR. GIBSON said he agreed with Dr. Allen.

DR. FORDYCE said he thought the lesion was a syphilitic epididymitis. The principal pathological changes were probably gummatous in character.

DR. KEYES said that while the growth lacked some of the features of a syphilitic epididymitis, at the same time it resembled that more closely than it did the tubercular form of inflammation. He advised vigorous specific treatment in order to clear up the diagnosis.

DR. ALEXANDER said that the slow progress made by the growth and the non-involvement of the cord were both in favor of the diagnosis of syphilitic epididymitis. That is the only form of epididymitis in which the cord is not involved. Tubercular epididymitis could be ruled out by making an examination of the seminal vesicles. If they are not involved by this time the case is probably not tubercular.

DR. FULLER said that on account of the non-involvement of the cord and the lack of tenderness the case was probably syphilitic. He referred to the fact that many cases of specific epididymitis occurring late in the course of the disease are associated with hydrocele; there were no evidences of fluid in this case.

DR. TAYLOR said he did not care to venture a positive diagnosis without examining the seminal vesicles and the prostate. The case was probably syphilitic.

DR. GOLDENBERG said he regarded the case as one of syphilitic epididymitis, and he advised local massage with mercurial ointment.

DR. GUITERAS said he thought the case was one of syphilis, and the man is now on mixed treatment. This has not been continued long enough, however, to verify the diagnosis, and there is still a possibility that the in-

flammation is a tubercular one. The prostate is somewhat enlarged. Nothing abnormal was noticed about the seminal vesicles.

**A Case of Castration for Hypertrophy of the Prostate.**—Reported by DR. F. FREMONT SMITH, of St. Augustine, Fla.

The patient was a man aged 69 years, who was admitted to the hospital on October 25, 1893. He gave a history of prostatic hypertrophy and complained of frequent and painful micturition, with numerous attacks of acute retention. At the time of his admittance to the hospital and for some weeks previously he suffered from irregular febrile disturbances. His urine was ammoniacal and loaded with pus, and the smallest amount of residual urine found in the bladder was six ounces. For nearly two months after the man's admission to the hospital the bladder was systematically washed out and internal treatment was given. The patient, however, failed to improve. He had a number of attacks of acute cystitis, with septic fever, and his weight was reduced from 165 to 135 pounds. It was then decided to treat the case by castration. This operation was performed on February 17, 1894, and the man was discharged six weeks afterward; his condition was much improved, and this improvement has steadily continued. He has no more fever, his appetite has returned and his weight has increased to 163 pounds. His mental condition is also very much improved. As regards the local symptoms, he has had no more attacks of acute cystitis, and the amount of residual urine ranges from one and one-half to three drams. Formerly he was obliged to urinate from twelve to fifteen times at night; now he urinates from four to six times and the act is not associated with any pain. The character of the urine has also very much improved.

In conclusion, Dr. Smith cited an article on this subject by Dr. J. William White (*Annals of Surgery*, 1893,) in which reference is made to the analogy that has been traced between uterine fibromata in the female and prostatic hypertrophy in the male, and certain experiments on dogs are detailed which show the influence of castration upon the condition of the prostate, resulting in a reduction both in its weight and bulk.

DR. KEYES said he regarded the treatment of prostatic hypertrophy by castration as too radical.

DR. ALEXANDER said that he also regarded castration as too severe a measure to be employed for the relief of symptoms due to prostatic hypertrophy. Symptoms like those in the case reported by Dr. Smith can usually be relieved by other and milder measures; the febrile disturbance was probably due to faulty antisepsis. The tendency to sacrifice the testicles, which appears to be very prevalent nowadays, Dr. Alexander thought should be discouraged. For example, in cases of tubercular testis the partial excision is so successful that total extirpation is frequently unnecessary.

DR. FULLER said that in Dr. Smith's case the symptoms pointed to an acute inflammatory process which would probably have subsided under antiseptic treatment, rest in bed, etc., without the aid of castration. He did not think the experiments that have been performed on animals were of much importance as bearing on this question; in those animals the sexual function was active, while prostatic hypertrophy is usually met with in old men whose sexual function is nearly extinct and in whom the gland is chiefly composed of fibrous tissue. It is not likely, therefore, that it would shrink very much by cutting out the testicles.



DR. GUITERAS said he did not think the treatment of prostatic hypertrophy by castration would become popular; the operation was too heroic.

DR. C. W. ALLEN said he had been much interested in listening to Dr Smith's report of his case and its successful treatment by a method which he has seen theoretically discussed in literature. Fibroid tumors of the uterus, as we know, shrink and undergo involution after the woman has passed the age of functional activity of the ovaries; and if it is true that an analogy exists between such tumors and an enlarged prostate, the latter, it seems, should also undergo involution after a certain age without the aid of castration. At present the subject must be regarded as purely theoretical, and it can only be proven by a sufficient number of cases like the one reported by Dr. Smith.

DR. TAYLOR referred to the experiments of Mr. Reginald Harrison and others on this subject, preceding those of Dr. White. It has also been proposed to cut the vas deferens instead of performing castration.

DR. GOLDENBERG stated that a number of cases of prostatic hypertrophy have been reported which were successfully treated by cutting off the blood supply to the prostate.

DR. SMITH, in closing the discussion, said he did not advocate castration in the treatment of prostatic hypertrophy. He simply wished to show the beneficial results following its performance in the case narrated. Under the ordinary method of treatment, as he had seen it carried out by some of the gentlemen who took part in the discussion—that is, rest in bed, washing the bladder, etc.—his patient was gradually growing worse. After castration there was rapid and marked improvement.

**Case of Miliary Papular Syphilide.**—DR. FORDYCE presented a patient, a negro, who showed an unusual development of the small miliary papular syphilide. On the arms the eruption was of exceptional development, although presenting typical features of the syphilide in question.

**Castration for Tubercular Testis.**—DR. C. L. GIBSON read a paper on this subject.

The author first reviewed the objections that are urged against castration for the relief of tubercular testis. A frequent objection advanced against castration in these cases is that it is a serious and dangerous operation. This only holds good in those cases where the general condition of the patient is such that it is unsafe to administer an anæsthetic, or where the local and general manifestations are far advanced, or where the testicular disease is rendered insignificant as compared with the bladder and kidney manifestations, even if the lungs are not seriously involved. The modern operation, *per se*, is almost devoid of danger. In favorable cases it is perfectly possible for the patient to resume his work in ten days.

Another objection urged against castration is that the loss of one or both testicles is likely to be followed by severe psychical disturbances. In cases where only one testicle is to be removed this fear of mental sequelæ should not be allowed to stand in the way of operation. It seems reasonable to urge the patient to part with an useless organ on the ground alone that the operation is likely to secure immunity of the remaining gland. Again, where the offending testicle is painful and sinuses have formed, is it not common sense to expect that the removal of a constant reminder of

his crippled sexual apparatus will improve the patient's mental condition? The substitution of a celluloid testicle, as has been successfully done by Dr. R. F. Weir, gives us a resource where we think an operation is indicated, even in the presence of a markedly neuræsthenic condition. As regards double castration no rules can be formulated. The procedure is seldom called for, certainly not as a curative operation in the sense of thereby eradicating tubercular disease from the body. Even in the double operation the mental symptoms are probably dreaded to an exaggerated degree.

As regards the third objection, that a tubercular testis is always a part of a general tubercular disturbance, statistics show that this statement is not based on facts. According to a number of observers, two-thirds of the patients with tubercular testis are free from pulmonary tuberculosis. The objection based on the belief that a tubercular testicle is always a part of a similar process elsewhere in the genito-urinary tract, or secondary to it, is an important one, but its correctness has not been proven. Guyon states that the epididymis is never the seat of the primary affection; he looks upon the process as ascending from the seminal vesicle to the epididymis. In opposition to this theory, Jacobson claims that the disease is generally primary in the epididymis, the infection being carried by the blood supply, the complex condition of the vascular distribution favoring the deposit of the bacilli there. The disease, when seen early, is generally located in the head of the epididymis, and all the anatomical conditions seem to favor the priority of the process there. Again, there is the possibility of infection ascending from the seminal vesicle through exposure by coitus. The disease may be congenital, and often enough the tubercular trouble seems to follow directly upon a traumatism.

Another objection made is that the operation may provoke an explosion of latent tubercular disease in other parts of the body. This objection cannot be regarded as a very potent one. This may occur as a coincidence, but Dr. Gibson said such a case has never come under his observation.

The speaker then referred to some of the advantages of castration for tubercular disease of the testis. One of the most important of these is that by early operation the disease may often be eradicated. Furthermore, as a palliative operation, castration very often finds its warmest support. Guyon rejects the operation excepting when demanded by symptoms, when he is enthusiastic as to its benefits. As a palliative operation, in the purest sense of the word, castration may relieve the patient from a distressing, painful and exhausting process, even in the case of a general genito-urinary tuberculosis, provided always that the condition of the patient offers the chance of his obtaining enough proportionate relief to warrant any such measures.

DR. ALEXANDER said he was in favor of excision rather than extirpation in the treatment of these cases. In the vast majority of cases of tuberculosis in this region, even where the cord is involved, an operation which consists of removing the epididymis, and then drawing down and cutting off the vas deferens as high up as possible, will give more satisfactory results than castration.

DR. KEYES said that in patients with tubercular testis he has always found evidences of catarrhal disease in the urethra. He is of the opinion that the tubercular disease, in nearly every instance, is a descending process. Unless it is absolutely necessary, the entire testicle should not be sacrificed in operating on these patients. It is easy to dissect off the epididymis, and

then, by pulling down the vas deferens, the greater part of the diseased tissue can be removed. Of course, if the testis itself is obviously diseased, it should be removed. Partial excision, however, as a rule yields admirable results.

DR. FULLER said he was fully in accord with the views expressed by Dr. Keyes. He regarded tuberculosis of the testis as the result of a descending process, although the cord, in some cases, may not be apparently involved.

DR. TAYLOR said the plan of operation in these cases depends on the amount of tissue involved. In some instances resection is indicated; in others, removal of the testicle.

DR. GIBSON, in closing the discussion, expressed the opinion that resection was applicable to only a small percentage of these cases. In the majority of instances, when these patients come under our observation, the disease has already invaded the testis, and resection is of very doubtful utility.

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## Book Review.

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*A Practical Treatise on the Disease of the Hair and Scalp.* By GEORGE THOMAS JACKSON, M.D. New revised and enlarged edition. New York: E. B. Treat, 1894.

The first edition of this most excellent little work was published in 1887.

It was so well received by the profession, the author wisely concluded to revise it and bring it up to date.

Several new subjects have been added, and many of the chapters rewritten and enlarged.

According to the author, alopecia prematura, when not due to destructive diseases, is, in the majority of cases, caused by seborrhœa and pityriasis simplex. The latter is now considered to be of parasitic origin, and while if left to itself it may produce complete and permanent baldness, by proper care of the scalp and judicious treatment in its early stages it is in most cases curable.

Much space is devoted to a consideration of the recent investigations concerning the etiology of alopecia areata, and many authors of diverse opinions are quoted. Summing up the evidence as presented, the author concludes "until further light is thrown on the subject it is probably best to hold that there are some cases which are contagious and may be parasitic, and some which are non-contagious and neurotic."

A variety of atrophy of the hair is newly described under the name of *aplasia pilorum propria*. It differs from trichorrhæxis nodosa in that the nodes are the normal parts of the hair and the fracture takes place in the internodular parts. It is a congenital disease, and is not amenable to treatment.

Under the title *folliculitis decalvans* is a well-written and concise description of a group of diseases characterized by a follicular inflammation of the hairy parts, followed by cicatrization and permanent baldness which

has occupied the attention of French writers during recent years, and which has been recognized under various names.

In the chapter on trichophytosis capitis the author gives at some length the researches of Sabouraud, which he considers to be "one of the most important contributions to our knowledge of ringworm." Sabouraud shows that there are several distinct species of fungi which are capable of causing ringworm in different animals. In the human there are two principal varieties; the first has small spores and is found only upon the scalp, and is most difficult to cure; the second has large spores and may occur upon the scalp, when it is easily cured, and is the form found in the beard. This latter form, together with another special large spore species, is the cause of ringworm of the body.

The treatment of trichophytosis has not advanced very much, however, although many new methods are mentioned.

Under the rarer parasitic diseases is described *leptothrix*, a disease due to the growth of bacilli upon the hair of the axillæ and scrotum in persons who sweat freely.

The chapter on *dandruff* is considerably amplified, and considers *eczema seborrhoicum* among its synonyms. In regard to its etiology the author states that "the parasitic and contagious theory of its origin is gaining ground."

The bibliography at the end of the book is brought down to January, 1893, and contains over four hundred additional references.

The entire book gives evidence of a careful and thorough revision, and the author has admirably succeeded in presenting the latest views of recent investigators in this field, and has on the whole given us the most complete and satisfactory work on diseases of the hair and scalp that I know of.

C. C. R.

## Selections.

**Pseudo-Chancres.** J. P. GAYON, City of Mexico. (*Gaceta Médica de Mexico*, Tomo XXX., No. 2.)

The author states that any simple ulceration under the local irritating influence of calomel, a caustic, or even from inflammation of the tissues may simulate a hard chancre. The site of the lesion exerts a great influence upon the development of induration, for, in the nose and the balano-preputial sulcus, the anatomic disposition of the tissues and the lack of elasticity contribute to produce circumscribed indurations. Any lesion of the superficial layers of the skin or a herpetic eruption, in these regions may be complicated with an induration, without any specific element. Any lesion or eruption in the balano-preputial sulcus is accompanied by more or less induration. Certain syphilides of the mucous membranes take on a certain degree of induration and may simulate a primary sore. This variety being of the papulo-erosive form and from its site, indolence, volume, configuration, evolution and course may so simulate a primary sclerosis that confusion is easy. During the third stage the gummata of the genital organs during ulceration may assume the appearance of the primary sore. They first



feel like a foreign body beneath the skin, from their cartilaginous hardness. After a time they approach the skin and, by ulcerating, may resemble either a hard or soft chancre. He concludes as follows:

1. Simple ulcerations of the genital organs by reason of their site or inadequate treatment may simulate a hard chancre.

2. Soft chancres either from these same causes or from developing in a syphilitic organism may also give rise to the same confusion.

3. Certain syphilides of the secondary and syphilomata of the tertiary period may perfectly assume the characteristics of the initial lesion of syphilis.

F. H. PRITCHARD.

**On Extragenital Syphilitic Infection.** DR. RUDOLPH KRAEFTING, Christiania, Norway. (*Norsk Magazin for Lægevidenskaben*, No. II., 1893.)

The writer has made a study of the cases of extragenital syphilitic infection observed in the clinic of that city. From 1867 to 1891 2,916 cases of syphilis presented 539 cases of extragenital infection, 15.6 per cent. of the total number of the cases. Of these 292 were adults, 61 males and 231 females and 247 children. Of the males 4.3 per cent., of the females 12.8 per cent. contracted it extragenitally. Since the suppression of official control of syphilis in 1888 genital syphilis has increased, while extragenital infection has decreased. In two hundred and eighty cases the primary lesion was situated as follows:

Lips,	142 cases,	35 males,	77 females,	30 children.
Gums,	1 "	1 "	— "	— "
Tongue,	11 "	3 "	3 "	5 "
Fauces,	58 "	11 "	47 "	"
Mammae,	58 "	— "	58 "	"
Chin,	1 "	— "	1 "	"
Forehead,	1 "	— "	1 "	"
Scalp,	2 "	1 "	1 "	"
Thigh,	1 "	— "	1 "	"
Abdomen.	1 "	1 "	— "	"
Fingers,	4 "	3 "	1 "	"

Regional glandular swellings often give valuable symptomatological indications on the mode of invasion, even when the traces of the primary lesion are but indistinct. In labial and faucial infection there is nearly always an asymmetric enlargement of the neighboring glands and a resultant deformity of the neck. In chancre of the tonsil induration was often observed but it is not indispensable. In lesions of the mammary gland induration was always present and diagnosis presented no difficulties. In all the cases, excepting one hundred, there was a clear history as to the method of contagion. In three-fourths of them infection was attributed to contaminated drinking vessels, pipes or cigars, kissing, infection of the nursing by the nurse or vice versa.

He mentions twenty-two cases where there was a veritable epidemic, affecting a whole house or family. As to evolution, severe forms seemed to be relatively frequent. In adults with the primary sore on the fingers or mammae the disease often assumed a malignant character, with late recurrences. As to the treatment, it differed from the ordinary in that mercuri-

als were only exceptionally employed while the iodide of potash was used, especially when there was a tendency to chronicity. Tonics were also administered, iron and quinine. In iritis, atropine, vesicatories and leeches to the temples and the iodide were used.

F. H. PRITCHARD.

**Bilateral Inguinal Buboës from Pediculosis Pubis.**—DR. R. KRAEFTING, of Christiania. (*Norsk Magazin for Lægevidenskaben*, No. 1, 1894.)

The writer reports the case of a young man of twenty-three years, who came under treatment for a bubo in each groin but who presented neither a soft chancre, balanitis nor a gonorrhœa. Examination revealed an enormous quantity of pediculi pubis, which had given rise to eczematous patches above the pubic symphysis. A certain quantity of pus was extracted from the right bubo but no micro-organism could be discovered either by the microscope, culture or inoculation. The leucocytes stained imperfectly—sign of degeneration. Otherwise, they pursued the course of ordinary non-virulent buboës after soft chancres and were but slightly inflamed. The pus was of a grayish color and herein differed from the chocolate-brown pus of virulent buboës and the yellowish-green pus of ordinary abscesses. He leaves it undecided whether the suppuration here was due to products excreted by the pediculi or to an irritation of the skin from their presence. No microbes could, however, be made out with the usual methods of investigation. Under a compressing bandage the pus was, in a great measure, absorbed as with non-virulent buboës, after soft chancres.

FRANK H. PRITCHARD.

**Trichophyton Tonsurans.**—DR. AMEDEO MARIANELLI. (*Lo Sperimentale*, Fasc., V. and VI., p. 440.)

The writer, from a series of experiments and observations on the nature of the parasite of this affection, comes to the following conclusions:

1. The morphological diversity both macroscopic and microscopic, which is observed in different colonies from different cases of this disease, or in different inoculations or transplantations of the same colony, are not dependent upon difference in the species but upon external circumstances, and principally upon the greater or less dryness of the culture media, the age of the culture, the difference in reaction or concentration of the nutritive media themselves, the temperature, the supply of air, etc. There is no constant correspondence between the appearance of the colony and the clinical case whence it was taken.

2. The distinction of one variety, trichophyton, from small, and another from large spores, as two distinct species, is not advisable. There are examples of the two existing at the same time, in the same person, along with the ordinary varieties, or in the same family, in different persons. The trichophyton gigas and the trichophyton gracile are nearly always present, simultaneously, in onychomycosis trichophytic.

3. Clinical observations and experiments rather point to a unicity than a plurality of the species of the pathogenic parasite, trichophyton, in man, at least.

4. The diseased hairs as well as cultures of the parasite may preserve their vitality and virulence for years.

5. Compared with other parasites, the achorion Schoenleinii included,

the trichophyton will flourish most vigorously, and if existing together will kill out the others.

6. If placed together with the common pyogenic micro-organisms, the staphylococcus pyogenes aureus and the streptococcus, in case that these latter retain their full virulence they will overwhelm, prevent or arrest the growth of the trichophyton.

FRANK H. PRITCHARD.

**Carbolic Acid in Malignant Pustule.**—DR. LEONE SESTINI. (*Lo Sperimentale*. No. 4, 1894.)

The writer highly recommends Mafucci's method in the treatment of malignant pustule. This consists in parenchymatous injections of a solution of carbolic acid, varying in strength between one to three per cent., according to the gravity of the case. The injections are made both into the pustule and the zone of demarcation between the odema and the surrounding healthy tissue.

FRANK H. PRITCHARD.

**Diabetes Insipidus and Myxœdema of Syphilitic Origin.**—A. T. POSPIELOW. (*Med. Obozrenie*, 1893, Vol. XL.)

The patient had four relapses in the first five years after infection, notwithstanding a very active specific treatment. In the fifth year he suddenly began to vomit, which was aggravated by lifting the head. Aphasia and paresis of the left side also supervened. A course of specific treatment improved matters.

A year after—six years after infection—the patient noticed polydipsia to the amount of forty-eight glasses of water daily without satisfying his thirst, a painless enlargement of both testicles and at the same time a hazel-nut-sized nodule developed in the upper third of the thyroid cartilage of the same consistency as the testicular swellings. He experienced an unusual sensation of cold which compelled him to keep his bed during the day, although he had normal temperature (37 R.). The skin was quite dry and œdematous, without sweat, the nails brittle, the tongue red and dry and a general weakness prevailed. After an active specific treatment of six weeks the symptoms of sarcocele and diabetes disappeared and the knob on the thyroid gland passed away, leaving only a trace in form of puckered skin. But the unusual sensation of cold and the other symptoms of myxœdema remained.

The raw thycoid gland of a bull was given internally. After seven drachms of the gland had been administered during eight days pain in the back and extremities, trembling in the calves, apathy and an acceleration of the pulse appeared. At the same time the skin was covered with sweat for the first time in two years. The sensation of cold and the other symptoms of myxœdema entirely disappeared. Two weeks afterward polydipsia, with a dry tongue reappeared, but five sublimate injections entirely removed the symptoms. The patient felt quite well in every way.

The author regards the improvement of the patient as temporary only. Since the interstitial syphilitic infiltration destroyed the glandular structure the functions of that gland cannot be restored either by specific treatment or by the thyroid extract. Consequently the symptoms of myxœdema are liable to reappear.

LAPOWSKI.

**Erythema Elevatum Diutinum.** H. R. CROCKER AND CAMPBELL WILLIAMS. (*Brit. Jour. of Derm.*, January and February, 1894.)

The first installment of the paper is occupied with the history of four cases—the authors', one reported by Dr. Bury and two by Hutchinson, all of which, though differing somewhat as to detail, possess an undoubted similarity. The subject of the report may serve as a type. The patient, a girl of 6, with a strong family history of gout and rheumatism, presented a number of lesions on the knees, buttocks, elbows and hands, appearing in the order named. The first knuckle and the terminal phalanx at the border of the nail of the thumb, first and second fingers, the palmar surface of the same digits, the whole of the second finger and all but the proximal phalanx of the index were affected on the left hand; the same fingers, but not the thumb were attacked in much the same location on the right. The lesion in the right index finger most nearly typical was elevated one-eighth of an inch above the surface, convex, sharply defined, pale purplish red in color, with a few dilated vessels over it, paling somewhat on pressure, but diminishing very little in size, firm, very tender, with no subjective symptoms. On the knees, where involution was most complete, only some slight discoloration and thickening remained. The evolution was very slow, occupying months. Under arsenic, tinctura lupuli and locally a solution of liquor carbonis detergens, improvement occurred, but this may have been spontaneous. The lesions are primarily nodular in character, become confluent and form patches. In these characteristics, in the purple tint and in the constant presence of a gouty diathesis, all the cases resemble each other. Hutchinson's four cases, constituting one type, differ from the other type illustrated by Bury's, the authors' and an unpublished case in these particulars: in the former, the patients are all male and advanced in life, the lesions are not localized over articulations or on palmar surfaces, they are less developed, more œdematous and lack the firmness of the Bury variety. The latter always occurs in young females, with a personal "arthritic" history.

The microscope shows only what is to be expected from the clinical character of the lesions, "a chronic inflammatory process in which both plexuses of the corium take part but only the upper wall of the deep plexus is concerned. The seat of the morbid process is between the epidermis and deep portion of the corium adjacent to the coil-glands, all below these being normal. Within these limits is a fibro-cellular structure which in great part replaces the normal fibres of the corium. The fibres run in various directions, following the course of the vessels (the cells lying between). The older the lesion the more will the new fibrous tissue be developed, until one would anticipate that in advanced cases, many of the patches would be composed almost entirely of fibrous tissue, and perhaps not unlike a keloid in structure." The name is justified merely by the clinical features.

JOHNSTON.





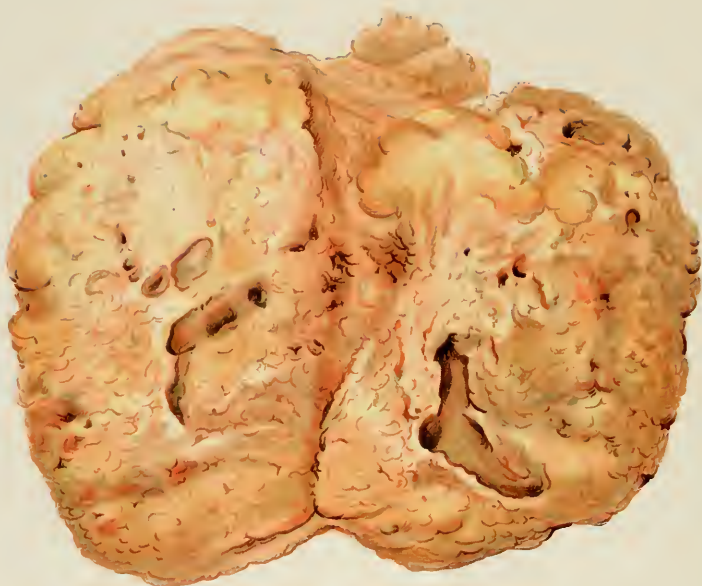


FIG. 2.—One third natural size.

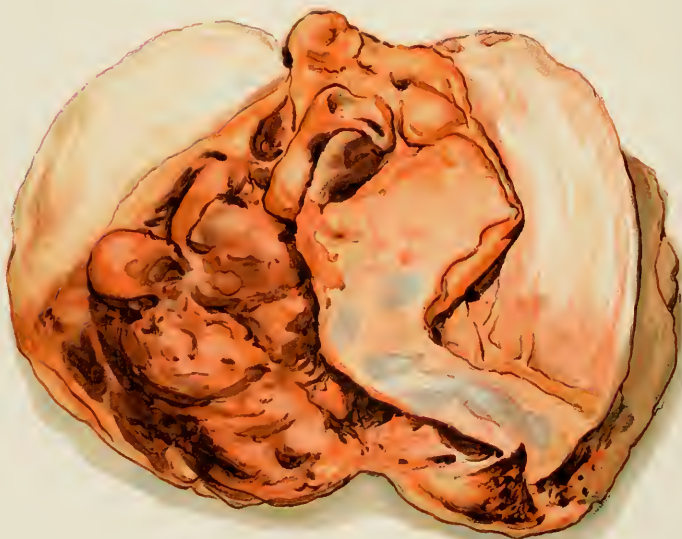


FIG. 1.—One third natural size.

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## Original Communications.

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### A CASE OF MIXED MALIGNANT DISEASE OF THE TESTICLE.<sup>1</sup>

BY

R. W. TAYLOR, M D.,

Surgeon to Bellevue Hospital, New York.

THE case, with specimen, which I now present is interesting in its clinical history, in its rarity and in its pathological anatomy.

The patient was a well-developed man with a good family history, an American and a brakeman, twenty-seven years old. He came to Bellevue Hospital February 19, 1894, and gave a confused account of a chancre in August, 1892, and he thought that a rash followed that lesion. No history or evidence of syphilis other than the foregoing could be obtained. He says that at about the same time that the chancre appeared he noticed a small hard lump at the upper part of right testicle. This lump remained small and indolent until August, 1893, when he was struck on the affected testis. Since that date the enlargement increased steadily. I first saw the patient in December, 1893, when the diseased testicle was of the size of a very large pear, firm and resistant in structure, smooth on its surface and very heavy. In fact, it presented all the features of a syphilitic sarcocele. Anti-syphilitic treatment generally and locally was administered, but with no benefit whatever. The

<sup>1</sup> Read before the American Association of Genito-Urinary Surgeons, June 1, 1894.

tumor steadily grew larger until it became of the size of a cocoanut and measured twelve inches in circumference and about seven inches in length. The man's duties as brakeman on the elevated road were arduous, and as a result the testicle was frequently squeezed and hurt. On admission, a large fungating mass could be felt on the lower posterior surface of the tumor. I removed the testis February 20th of this year, and perfect healing took place within a month.

The gross appearances of the tumor are well shown in the colored drawings. In Fig. 1 the large red fungating mass is well shown, together with the much-thickened visceral layer of the tunica vaginalis. In Fig. 2 the inner structure of the tumor is shown after it had been nearly cut through by an incision on its anterior surface. It consisted of quite firm tissue, which in some places was yellow and looked like fatty tissue, whereas in others it was of a pinkish hue. Both incised surfaces were studded by small and large cysts.

This form of testicular tumor (and the parotid gland is sometimes similarly affected) is quite rare and is found in the proportion of about three in one hundred cases of malignant disease of the testes. It occurs most frequently between the ages of twenty and forty, a large number of cases having been noted between thirty and forty and a smaller number between twenty and thirty. It may occur in early and in late life, but the cases in which it is thus observed are quite rare.

The disease begins slowly and insidiously, without marked subjective symptoms. As the growth increases a smooth, hard, firm, sometimes densely elastic indolent tumor is produced. There is no spontaneous pain present and the patient simply complains of a dragging sensation, together with the impediment offered by the size of the tumor. Hydrocele is sometimes a complication. Being smooth, hard and firm in its early days, this form of testicular degeneration may be regarded as syphilitic, so much does it resemble syphilitic sarcocele. But the touchstone to the diagnosis lies in treatment. It is always well in these cases, and even if the history is misleading or even negative, to put the patient under an active local and general syphilitic treatment. If the disease is of specific origin, the morbid process will be arrested and the tumor will gradually subside to its normal size. If it is of malignant nature it will go on increasing in spite of medicine and then the surgeon knows that ablation is necessary. Usually the surface of the tumor in its early months is smooth, but sometimes it becomes nodu-



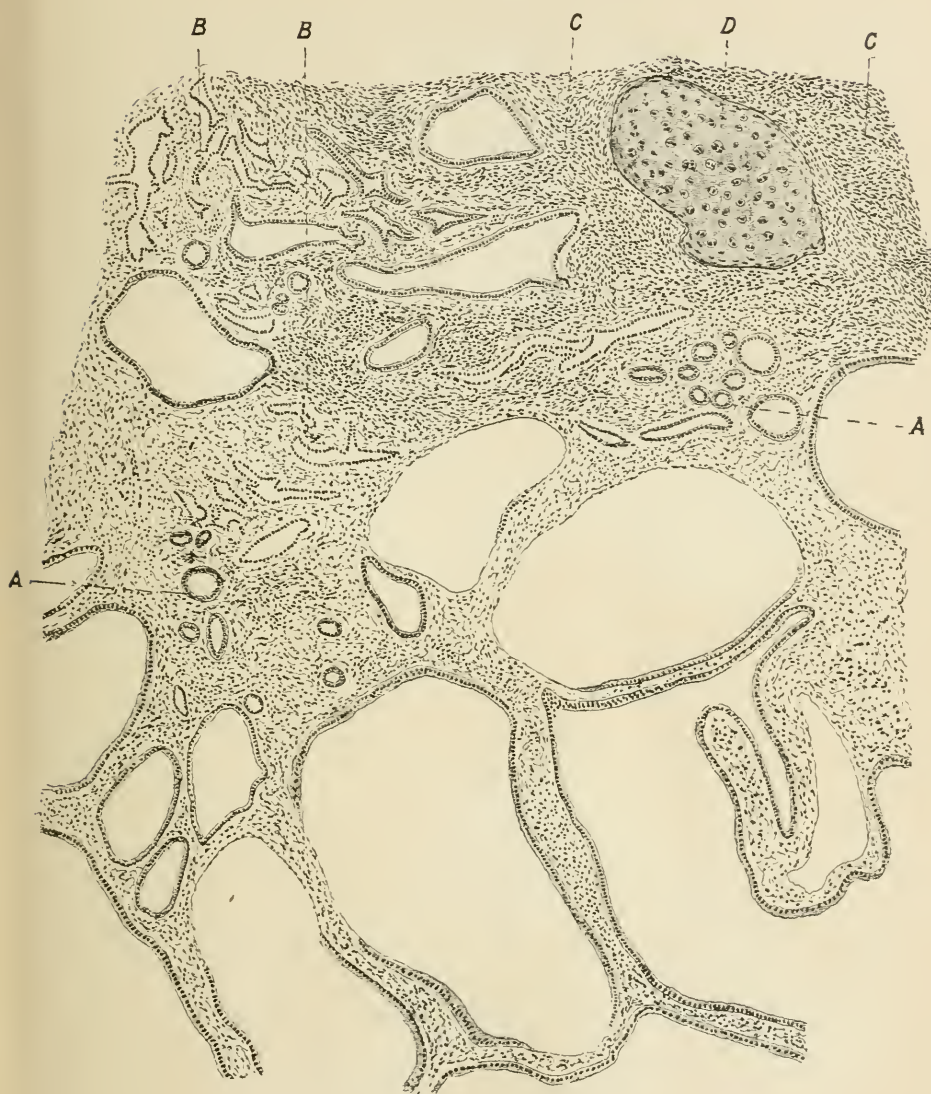


FIG. 3.

EXPLANATION OF CUT.

- aa—Portions of the tumor showing the perfect type of adenoma.
- bb—A less perfect form of adenoma on the border-line of carcinoma.
- cc—Sarcomatous tissue.
- d—Hyalin cartilage.

lar, rugose or bossy quite early. In this event the suspicion of malignancy is warranted. In the case reported nodulation followed by exuberant fungous développement occurred about eighteen months after the onset of the disease. The microscopical study and the figure delineating the structure of this tumor have been made for me by Dr. Ira Van Gieson with his customary accuracy and skill.

*Microscopical Examination.*—The testicle and epididymis are uniformly enlarged in all of their diameters; the latter is about one and three-fourth times its natural size. The testicle is largely composed of a congeries of variously sized vesicles and cysts, the larger of which measure one-half centimetre. In places the cysts are very closely approximated, communicating with each other and lined by thin walls.

Sections from various regions of the growth demonstrate the following structure: (See Fig. 3.)

1. Small regularly spherical acini lined by cylindrical epithelium (aa). These correspond to the typical adenoma portions of the tumor.

2. Other very irregular branching cavities, lined by less regularly disposed columnar cells (bb). These cavities indicate a departure from the perfect adenoma type and are on the border-line of carcinoma, so that the tumor here is really adeno-carcinoma.

3. Very large cavities (see left-hand side of drawing) lined with epithelium and frequently filled with granular and fluid material. These represent the cystic transformation of the adenomatous portions of the tumor.

4. Tiny islands of hyalin cartilage (d).

5. The remainder of the tumor is composed of closely-packed small spindle-shaped cells (cc.) or tissue in the various stages of productive inflammation. The small spindle-celled tissue is arranged in the way characteristic of sarcoma.

The tumor, then, is complex and is formed of

sarcoma	
chondroma	} cystic
adenoma	

MODIFICATIONS OF BIGELOW'S OPERATION FOR STONE IN  
THE BLADDER. DESIGNED TO MEET CASES IN WHICH  
THE PROSTATE IS ENLARGED.<sup>1</sup>

BY

GEORGE CHISMORE, M.D.,

San Francisco, Cal.

THE difficulty of clearing the bladder of stone by Bigelow's method increases in direct proportion to the amount and character of the encroachment upon that viscus by senile enlargement of the prostate gland.

As the hypertrophied mass pushes its way upward the bladder ceases to be spheroidal in shape, is dented in, so to speak, and in extreme cases is stretched, cap-like, over the intruding growth. When, as in most cases, the growth is lobulated, pouches and folds are formed capable of holding a small stone, or fragments of a large one.

These conditions, together with the consequent alteration of the relations of the vesical orifice of the urethra, make it impossible to command considerable portions of the cavity of the bladder with the lithotrite, or, indeed, any instrument introduced through the urethra, or a perineal incision, besides furnishing hiding places for the escape and retention of fragments of calculi during litholapaxy.

Under such conditions, is it worth while to attempt to remove a stone by crushing? Can it be done with sufficient safety, celerity, and certainty to warrant a trial? If so, how shall we proceed in order to minimize the danger and suffering to our patients?

To answer these questions is the object of this paper.

Out of seventy-one litholapaxies made by the writer fifty-two have been cases in which senile enlargement in varying degree—all but five requiring the catheter—was present. The experience gained in these cases furnishes an affirmative answer to the first and second questions, and a description of the method I have come to employ is respectfully submitted as an attempt to answer the last.

The modifications of the classical operation suggested are as follows:

1st. Substituting local for general anesthesia in cases where an anesthetic is required.

2d. Short sittings. Continue crushing only so long as frag-

<sup>1</sup> Read before the Eighth Annual Meeting of the American Association of Genito-Urinary Surgeons, Washington, D. C., May 29 to June 1, 1894.

ments can easily be found. Wash out the pieces, and stop the moment symptoms of exhaustion, spasm of the bladder, or unusual distress occur.

3d. Remove remaining pieces, after symptoms due to previous operation have subsided, as soon as they can be felt by the searcher—usually within a week—and repeat the process until the bladder is cleared.

It will be observed that the operation thus conducted ceases to be a litholapaxy in Bigelow's sense, *i.e.*, the clearing the bladder at all hazards in one sitting, and differs from a lithotripsy in that all fragments small enough to pass the urethra are removed as soon as crushed.

When a patient presents himself for treatment with senile enlargement of the prostate and a stone, he is usually dependent on the catheter—has catheter stricture—and requires a course of dilatation of the urethra preliminary to attacking the calculus. This period is utilized in gaining his confidence, locating the habitual situation of the stone by means of the searcher, and attending to his general health. As soon as a 16 or 18 Van Buren sound will pass, I seize the first favorable opportunity, *and in my office*, empty his bladder, inject from 1 to 2 fluid ounces 4 per cent. solution cocaine muriat., gently insert the lithotrite, seize and crush the stone. If during this procedure I become aware—as I sometimes do—that quite a large fragment has apparently vanished, I do not make prolonged attempts to find it. It is perhaps in some pouch, or lying in a fold between two projecting knobs of the prostate, or firmly imprisoned in the deep sulcus formed by the bladder wall doubled upon itself by the intruding gland, in any case entirely beyond the reach of instruments, and there it will remain until it becomes slippery with mucous, or in some other way dislodged.

When no more pieces can be found, the lithotrite is removed, a catheter as large as will pass inserted, and the bladder washed with a warm borated solution, until the fragments cease to come. The patient is then sent home, with orders to keep quiet and warm, send for me if needed, and, if all goes well, come back in three or four days.

In the great majority of cases there are no after symptoms—the patient is better at once. Now and then difficulty in passing the catheter, due to swelling of the deep urethra, demands attention.

The patient's statement is an excellent and reliable guide in case of remaining pieces. Although at first he feels nothing,



if a fragment be there sooner or later the old symptoms recur, frequency of micturition attended with spasm, the urine becomes loaded with pus and mucous, he "feels a stone," and on search it will be found, usually, in the locality where its predecessor habitually rested. As a rule no anesthetic is needed to remove such fragments, and after two or three sittings the bladder is cleared.

An assistant is desirable, but the operation may be managed alone without much difficulty.

Briefly summarized, of my 52 cases the youngest was 51 the oldest 74, average 66.36 years. These were 22 phosphates, 24 oxalates, 5 urates, and 1 mixed oxalate and urate. The smallest weighed, dry, 7 and the largest 1,000 grains; average weight, 149 grains. There were no deaths and no serious complications attributable to these operations.

In my earlier operations, under general anesthesia and prolonged manipulation, there was much after-soreness and considerable pain and difficulty in using the catheter for several days. Since adopting the method described I have been astonished at the very slight distress following the removal of even large and hard stones.

Since completing my lithotrite I have gradually come to use it almost exclusively, although I still employ Bigelow's for a preliminary crushing in very hard stones, which I have found, by trial, so resistant as to endanger the breaking, or spreading of the jaws, of mine. It may be said in passing that it is now ten years since I began the use of my instruments, as made by Geo. Tiemann & Co., and I have never broken or spread one. Still, it is not nearly so strong as Bigelow's, and I have used the latter in five of my last forty-four cases. By connecting my lithotrite with the aspirator I am often able to suck a stone, or fragment, into its grasp that I could not catch in any other way.

My aspirator I use entirely. Although the operation can be done with most of the instruments now in use, I naturally prefer my own.

With the exception of four cases, which will be detailed later, these operations, so far as I have been able to observe, and I have seen most of the patients repeatedly, have accomplished all that could be reasonably hoped for by any method of procedure. It may be doubted if a bladder that has long borne a stone is ever quite restored to health, and still more so when "catheter life" has begun and when the prostate is

greatly enlarged; still, a degree of comfort has been attained and retained that under the circumstances is very gratifying.

Of the four cases alluded to, one passed out of my hands after I had removed 164 grains of a phosphatic calculus at one sitting. I knew, and he was told that a piece remained which, owing to his condition, I thought safer to leave for another occasion. He thought fit to apply to another surgeon, was cut, and a small piece found. I know of no reason for his changing physicians unless it be that he was one of those persons who "find it cheaper to move than pay rent," especially as I received nothing from him.

The other three cases have been subject to frequent recurrence. One has been under observation ten, the other six years each, all are living, subject to periods of more or less suffering at irregular intervals.

Two of them I cut by the supra-pubic route, in order to be sure that the bladder was clear; in one, after I had repeatedly removed stones by crushing, and in both I have repeatedly found, crushed, and removed stones since the cystotomy. Both these patients regard a litholapaxy as of little moment, but have a wholesome dread of lithotomy. The last one of the four is an oxalate factory. In 1884 I crushed and aspirated an oxalate weighing 820 grains for him. At that time the prostate was somewhat enlarged. He was quite comfortable for four years, when an attack of retention paralyzed the bladder, and made him dependent on the catheter. Soon after symptoms of stone reappeared, and I found and removed it. Since that date, at intervals of from a week to a year, he comes to me with "another." He comes to my office Saturday night, has the operation without an anesthetic, goes to his work on Monday morning, and I see no more of him until the next. I kept notes of his case until I had removed over 1,200 grains in all, but for a long time I have neither noted the times of crushing or quantity removed.

With the exception of the first operation he has never been confined to his bed a day, and his general condition has been fairly good. Observing the immunity from after-suffering in this case led me to make cautious trial of operating, in my office, upon others. No bad results followed, and for the last two years I have done so almost exclusively.

In addressing this association, all reference to the history of litholapaxy, its results in other hands, proposed modifications, statistics, and literature has been purposely omitted by

the writer, there being no intention on his part to occupy the time with matters familiar to each member.

Minute details and many observations essential to a consideration of the subject before a general audience have been left out for the same reason. The only aim has been to present the personal experience of the author and his conclusions drawn therefrom. These may be stated as follows: In all cases of stone in the bladder where senile enlargement of the prostate gland exists, the operation described affords a reasonable probability of success, provided the urethra is, or can be made, large enough to admit the instruments; that, in such cases, it is possible by this method, with less suffering and danger to the patient, to remove any stone that can be gotten thorough a perineal incision; that the results are quite as good, both as to relief or recurrence, as to those attained by cutting—either "high" or "low"—and that, as a rule, the time required to clear the bladder is not greater than that which is necessary to recover from a supra-pubic lithotomy.

Forty-eight of the calculi are herewith presented for your inspection; the remaining four, including the largest, were unfortunately lost on the occasion of moving my office during my absence, my student not considering them "worth saving."

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#### A FURTHER CONTRIBUTION ON AN "EPIDEMIC SKIN DISEASE."

BY

THOMAS D. SAVILL, M.D.,

London.

(Concluded from page 292.)

*Section III.—The cases originally described in 1891 were selected chiefly on account of their severity. But many of the original series, and most of those subsequently seen, have been of a much milder, sometimes even of a trivial, type; this is especially true of the young.*

THERE was a marked variation in the severity of the cases in 1891, and had they not all occurred at the same time, and in a perfect gradation series, it would undoubtedly have been difficult to class them all as one disease. But these facts, combined with the constant presence of exfoliation and definite duration, enabled one with certainty to declare the identity of the disease.

One of the cases in 1891 was that of a child, aged 4 (whose photograph is submitted herewith), who was in the infirmary for bronchitis, and who was attacked on August 10th with a few non-margined red patches on his neck, and a day or two later on his chest, abdomen and axillæ. They were followed by slight desquamation, without any previous exudation or vesicular stage. This patient was well again in three weeks. He had not more than six patches, and none of these were much larger than a crown. He suffered no inconvenience whatever from the malady.

The cases just referred to, under the care of Dr. Evans and Dr. Thorsby Jones, may also be mentioned as slighter cases—cases such as would attend the out-patients' department at any hospital. And finally a good proportion of the cases that I saw at Bethnal Green Workhouse during the outbreak last year were of quite a trivial description; and the eruption, though tending to be symmetrical, was comparatively scanty, and was attended with little or no inconvenience to the patient.

*Section IV.—The disease is not a rare one, and is very liable, especially when mild, to be classed as an eczema or a psoriasis—Diagnosis.*

In the preceding pages, and in various publications on the subject, reference has been made to upward of 500 cases which are known to have arisen in the years 1891, '92 and '93. In the face of these figures it is not possible to regard the disorder as rare, while in view of the high mortality during some years it must certainly be regarded as a serious one. Moreover, it seems highly probable that, if the disease were more widely known, many other epidemic and sporadic cases would have come to light.

For example, after the attention of medical men had been drawn to the malady in November, 1891, information was received by Mr. Jonathan Hutchinson of an outbreak, in all probability of a nature similar to the one in question, which had occurred in the Greenock Parochial Asylum five years before,<sup>1</sup> and Dr. F. A. Elkins, under whose care the patients were at the time, has since published particulars of that epidemic.<sup>2</sup> On that occasion about fifty patients exhibited the eruption and the other symptoms of the disease. Several of the attendants had slight attacks, as indeed did the Matron

<sup>1</sup> *Archives of Surgery*, January, 1892.

<sup>2</sup> *Medical Press and Circular*, April 5, 1893.



and Dr. Elkins himself. "The eruptions were by no means all of the same character, some being eczema, and others more like psoriasis," Dr. Elkins states.

Dr. Elkins states: The moist type seemed to be the commoner on this occasion; and the weakness, lassitude and torpidity present were very marked. The persons especially attacked were the old and feeble. About five per cent. died from the direct effects of the disease, excluding four other patients who, dying of other diseases, had the eruption upon them at death.

In March, 1893, Dr. Geoffrey Prance, of Edinburg, kindly sent me an account of two cases having all the features of the epidemic skin disease which had occurred some years before in the Cheltenham General Hospital, at a time when he was resident there.

I am informed that cases have also been published in other countries, and I trust that my medical confrères of other nations will accept my profound apologies for the fact that want of time and ignorance of their language have prevented my doing due justice to their publications.

*Diagnosis—Initial Eruption.*—According to the cases published in 1891, the eruption during the initial stage of the disease may present several different appearances: (1) A discrete papular rash; (2) An erythematopapular rash; (3) A macular or blotchy rash; (4) A ringed eruption, resembling ringworm.

Each of the four varieties of initial rash occurs with by no means equal frequency. Out of the 163 original cases only 6 started as rings, and only 14 as maculæ. The great majority began either with discrete papules or a papular erythema. All my subsequent experience has confirmed me in the opinion that the former is by far the most frequent mode of commencement in slight and moderate cases, while the latter is the most frequent in the severe cases. I have, by the kindness of several gentlemen, seen cases occurring in their private practices. These, for the most part, have been sporadic; the patients have been younger, the disease much slighter than most of my infirm cases, and the patients have suffered from little or no constitutional disturbance. In nearly all of these the initial rash consisted of small discrete papules collected into groups like constellations. In all, there was the subsequent exfoliation of the epidermis. But at first the rash consisted of groups of papules, and I have come to regard this kind of eruption as

being the most frequent mode of commencement of the disease.

But among the infirmity cases of 1892 I met with one more kind of initial rash—a kind of scurfy erythema without papules. Thus a man named Michael Joy, aged thirty-eight, admitted to Paddington Infirmary during the first week of September, 1892, complained of an irritation or “itchiness” of the forehead and other parts. Nothing was visible for two or three days. Then a faint scurfy redness with little or no elevation above the surface appeared on his forehead, and on other parts in patches with fading margins. This erythematous blush soon spread to the rest of the body. Sometimes it was a little moist in the flexures, but generally dry. It was scurfy even at the outset, and resulted in a bran-like desquamation. The eruption did not yield to the use of creolin baths, but he improved rapidly on ichthyol and tar soap. The case was a mild one, and his skin was quite well in five or six weeks. There was no elevation of temperature at any time, the urine was normal, and he suffered no inconvenience beyond the itching of skin.

This scurfy erythema is not an infrequent occurrence. Several of the 1892 cases began in a similar manner. Thus the eruption may be manifested in no fewer than five different forms. As far as my own experience extends, they are, in order of frequency:

- (1) Discrete papules, generally arranged in constellations.
- (2) A congested or erythemato-papular rash (which usually indicates severity).
- (3) A scurfy erythema, usually in patches (which generally heralds a mild attack).
- (4) Raised maculæ becoming confluent, not unlike urticaria.
- (5) Flat ringed papules spreading circumferentially into rings with pale depressed centers.

The disease is more amenable to treatment early, and as it is undoubtedly contagious, if only feebly so, it seems important to recognize it at the commencement if possible.

I have gradually come to regard all papular eruptions, especially if arranged in constellations, with suspicion, and to inquire minutely for possible sources of infection. It is important in such cases to watch for the desquamation or exfoliation which is sure to follow in a day or two, and later on to note the time when the eruption begins to fade.

It is interesting to observe with how large a number of differently named skin diseases this disease might be—and possibly





EPIDEMIC SKIN DISEASE.  
To show the usual discrete papular commencement



may have—been confused in its early stage. It is, however, quite possible to differentiate it by its subsequent progress.

*Diagnosis from Eczema.*—This curious disorder, so protean in its earlier stages, presents certain points of resemblance with many other maladies. It is not possible, on the present occasion, to enter minutely into the differential diagnosis from all the infinite variety of diseases it is, at the outset, likely to simulate. But it is necessary to mention the points of distinction which subsequent experience has confirmed as differentiating it from eczema, the disease it most closely resembles, except in regard to certain features of epidemicity, exfoliation, and definite duration.

ECZEMA.	EPIDEMIC SKIN DISEASE.
1. Attacks all ages, and children are very liable.	1. Children almost exempt ; old people specially prone.
2. Gout is a marked predisposing cause.	2. Gout offers no predisposition.
3. Constitutional disturbance always moderate and never fatal.	3. Constitutional disturbance often severe, and may be fatal.
4. Dried crusts thrown off, but exfoliation of cuticle not a marked feature of the disease. Dermal thickening absent or moderate.	4. Epidermal exfoliation a constant feature. It may occur in some places without previous eruption. Dermal thickening generally present.
5. Exudation nearly always present.	5. Exudation may be slight, transient, or absent.
6. Course not definite.	6. Course fairly definite.
7. Not hitherto regarded as contagious or epidemic.	7. Undoubtedly contagious and epidemic under certain conditions.

*Diagnosis from Pityriasis Rubra.*—In its earlier stages the disorder under consideration is not liable to be confused with the pityriasis rubra described by Hebra, Willan and Wilson. However, the skin, in severe cases of the dry type of the epidemic skin disease, if seen at a later stage, presents a very exact resemblance to the appearance of the skin in pityriasis. Nevertheless, in their course and progress the two diseases are fundamentally distinct. All the epidemic skin cases that were not fatal recovered their normal skin in a reasonable and fairly definite time, whereas pityriasis rubra has a very chronic course, and an indefinite duration.

*Section V.—Bacteriological researches since made with the exudation have failed to isolate any absolutely distinctive microbe, chiefly on account of the contamination with staphylococci.*

During the epidemic of 1891 I was able to make some experiments with the exudation obtained from several acute cases.<sup>1</sup> There was constantly present in these a microbe bearing some resemblance to staphylococcus albus, but, differing from it in always occurring as a diplococcus, in not liquefying gelatin, at any rate for many days, and in the shape, color and thickness of its cultures, which were thin and of a somewhat translucent, bluish-white tint. If staphylococcus albus was also present it could be separated by plate cultures. Dr. J. Risian Russell, by independent researches, detected the same organism in the blood and skin.

We were unable to make inquiry into the pathogenic properties of this microbe at that time, further than one experiment. A rabbit inoculated by Dr. Klein showed a scurfiness and redness of its ears, and died on the twelfth day, and subsequently Dr. Russell obtained from the blood the characteristic diplococcus and cultures.

In 1892 Mr. J. J. Clark was kind enough to investigate the blood taken from the left ventricle of the only fatal case in the Paddington Infirmary, but he was unable to obtain cultures of any sort. The case was that of a woman, aged 76, and the disease ran a very prolonged course, that is to say, was attended by a good many relapses; and she did not die for six months after she was first attacked. It is doubtful if the skin affection was the direct cause of death. It was not, therefore, a suitable case for investigation. It was from the more acute cases, in 1891, that my cultures were obtained. But my belief is that I had inadvertently allowed some corrosive sublimate to remain in the capillary tubes in the course of sterilization.

In 1893, by the courtesy of Dr. Knox, I collected some exudation from three of the Bethnal Green cases, which were at that time in a state of subsidence. Two of the cases only gave cultures of staphylococcus albus and aureus. But from the third a growth was obtained which contained, at least, two apparently distinct organisms, one of them being staphylococcus albus and the other resembled the diplococcus I sought. But I was wholly unable to separate them after carrying on a long series of cultures.

<sup>1</sup> *British Medical Journal*, January 9, 1892, and Monograph, page 33.

*Histology.*—In the severe and fatal cases there was an immense amount of highly vascular, newly formed, fibrous tissue in the derma, and other changes which have previously been illustrated and described.<sup>1</sup>

Dr. H. G. Piffard, of New York, who has been good enough to submit my microscopic sections to minute examination, points out that there is a "nuclear degeneration in the rete mucosum, causing an appearance which some have described as psorosperms," and he also observes "special activity in, and prominence of, the stratum granulosum."

He has been so good as to send me some beautiful photographs.

*Section VI.—Treatment.* *The most efficacious form of treatment is the creolin bath. Not only does it procure relief for the sufferer from the severe irritation, but it treats the disease on rational and scientific principles. It has been successful alike both in recent and protracted cases, after many other remedies have failed. So efficacious has this bath been that in my opinion the epidemic of 1892 was prevented by these means from exceeding the dimensions it did.*

The bath should consist of about fifteen gallons of comfortably warm water (about 95° F.) to which two and a half pints of a 1 per cent. solution of creolin is added. The patient takes a bath regularly once a day, in very bad cases twice a day, and stays in for about twenty minutes. It is best taken at night, and the patient is gently dried and put to bed. The earlier it is used in the disease the more efficacious it appears to be. A large number of cases have been treated in this way. The following cases, which have been under treatment in 1892 or '93, may be mentioned by way illustration.

William Tapping, aged 57, originally admitted for ulcer of the leg, had a severe attack of the dermatitis during the epidemic of 1891, but completely recovered. In May, 1892, when a few cases of the disease again arose, he was attacked for the second time, and again seriously. On both occasions it assumed the variety I have called "dermatitis sicca." At first he used a 1 per cent. ointment of creolin, made up with lanolin and water, which allayed the irritation, but the skin lesion steadily became worse and the whole body was soon involved. At the end of two weeks he was ordered a creolin bath each day and improvement set in at once. On June 3d the new skin

<sup>1</sup> Monograph, p. 34.

was so sore from the exfoliation that the creolin ointment was substituted for the baths. He very soon grew worse and certain area, such as the back, which had quite recovered, now relapsed. Three weeks later he was again ordered a daily bath. He at once began to improve and in the course of two weeks was quite well. This was a case in which, on two occasions, marked improvement set in immediately the baths were given. Internal medication (mist Mag. Carb.  $\bar{c}$  Mag. Sulph.), and all surrounding conditions of the patient remained precisely the same all the while.

Henry Walker, aged 64, admitted originally for morbus coxæ occupied the next bed to William Tapping. His case resembled the latter in all the chief particulars. In his attack during 1892 the bath was suspended because of the pain in the hips caused by movement and he at once became worse. On resuming the baths he made a rapid and uninterrupted recovery.

John Woodcock, aged 46, originally admitted for biliary colic and choroiditis, had also suffered very severely in 1891. He relapsed many times in spite of varied treatment by arsenic internally, zinc, calamine, creolin ointments, Unna's paint of oxide of zinc, etc., etc., and finally the disease was succeeded by a chronic dermatitis of both arms which lasted eight or nine months. He became much worse during the epidemic of 1892. He was then treated perseveringly by the creolin baths daily for six weeks and ultimately got quite well.

*Creolin Ointment* ( $\frac{1}{2}$ , 1 and 2 per cent., rubbed up with lanolin and water in almost equal parts) ranks next to creolin baths in efficacy, especially if used in quite an early stage. In one or two cases we had reason to believe, as I have mentioned elsewhere, that it checked the spread of the eruption. In those very severe "moist," cases where large tracts of skin presented a raw profusely exuding surface, it seemed to be more soothing and suitable than the baths, but it was astonishing, even in these, how well the baths were supported.

*Ichthyol and tar soap* was used to four of the cases at Paddington in 1892, and in three of them caused marked amelioration, and in two of these the creolin baths were tried at first with little benefit, but as soon as the ichthyol and tar soap was used they made rapid progress. Creolin soap was also used with advantage in one case.

*Liquor carbonis detergens*, one drachm to the pint, with or without calamine, was of some value in cases of a more chronic



course, and in one case which occurred in the year 1892 (George Skinner, aged 65) the patient improved under it after many other remedies had failed.

*Carbolic lotion* (1 in 50 or 100) undoubtedly did harm in acute cases and in most of the cases of "Dermatitis Humida"; but applied quite early in the disease before the formation of vesicles, or in chronic dry cases, it was sometimes of value.

To allay the irritation from which they all suffered, *cold cream* (Ung. Galeni) was very efficacious especially for the dry cracked skin which occurred usually in the late stages of the disease.

*Zinc and calamine ointment* is a most valuable preparation for allaying the irritation, and on that account was very popular with the patients. We used it largely, and in certain cases it seemed to have a curative action, *e.g.*, in the case of Albert Dillon, aged 9, who had a slight attack in 1892, never having had it before. But here, as in some of the other cases where this remedy was used, there was not any distinct evidence that the disease would not have got well spontaneously. Zinc ointment of the British Pharmacopeia had a similarly beneficial effect of a sedative kind.

*A lotion of calamine* (20 grains to the ounce) with or without zinc oxide had a similarly sedative effect. It was also very popular with the patients, but many got worse under its use.

*Oxide of zinc powder* was a valuable application for the newly formed tender skin, when convalescence was established.

*A pigment of zinc oxide* prepared with gelatin (Unna) and painted on once or twice daily was tried in several cases, but without avail.

*Lanolin, vaseline* and a good many other things have been tried.

Corrosive sublimate lotion in any strength, invariably, in my experience, made the patients worse.

*Section VII.—Nosology.*—The name "General Exfoliative Epidemic Dermatitis," suggested by the author in 1892,<sup>1</sup> is an unfortunate one, because (*a*) the disease, although always exfoliated, has only sometimes a general distribution: only 25 per cent. at Bethnal Green. (*b*) It is only epidemic under certain conditions, *vide ante*. (*c*) Mild cases hardly amount to a dermatitis.

<sup>1</sup> Monograph, p. 39.

"Epidemic Skin Disease," the title first used,<sup>1</sup> has the merit of emphasizing the conditions under which the disease has attracted attention.

In its clinical features the disease under consideration belongs more to the eczematous than to any other group of skin diseases, although visible exudation may sometimes be absent. It might be said that the constant presence of exfoliation prevents it being so classified, and that it belongs to the exfoliative disorders. But, on the other hand, it may be urged, first, that pityriasis rubra, the most typical of exfoliative dermatites, which the Epidemic Skin Disease also somewhat resembles, has been regarded as an eczematous disease by some authorities.<sup>2</sup>

And secondly, the exudation, though apparently absent, could be detected on the under surface of the scales in some cases.<sup>3</sup> Dr. Colcott Fox, who saw many of the cases, also supports the view that the disease belongs to the eczematous class. Nevertheless it is differentiated from the eczema, as ordinarily met with, by the feature already referred to (*page ante*).

*Conclusion.*—In conclusion, it seems to me to be of the greatest importance both with a view to a recognition and study of this "Epidemic Skin Disease," and the prevention of outbreaks, such as those mentioned in the preceding pages, to bear in mind (1) that sporadic cases most certainly do occur, and (2) that the disease may present a very mild character, especially when it attacks the young.

The malady under consideration undoubtedly deserves more than passing attention. The multiform character of the rash, at least at the outset of the disease, is a feature of considerable interest to those who study skin maladies from a clinical standpoint; for the prime and essential cause of the different appearances presented by the skin was undoubtedly the same in all cases, yet the resulting conditions resemble many different skin affections hitherto described by different names.

To the pathological student it is of equal interest, not only by reason of the obscurity of its epidemic occurrence, but also by reason of the part—presuming our observations be correct—played by microbes in its origin and development.

The malady is, so far as I am aware, the only disease of the skin hitherto known to have arisen in outbreaks such as those

<sup>1</sup> Monograph, p. 5.

<sup>2</sup> Living. Diagnosis of Skin Diseases, p. 98.

<sup>3</sup> Monograph, p. 22.

at Paddington and at Marylebone in 1891, and at Bethnal Green in 1893. It is important in this connection to remember that the quality of contagiousness is often one of the last clinical features to be discovered in the history of a disease which is always more or less present (endemic) among a people. May it not be, therefore, that possibly eczema, psoriasis, pityriasis rubra and other endemic skin affections, which this Epidemic Skin Disease at one or other stage resembles, are in reality contagious maladies, albeit feebly so under ordinary conditions?

These and other questions of profound interest arise out of a study of this strange disorder, and it seemed to me that the most appropriate place to seek for guidance, advice and criticism in searching after the truth, under such circumstances, was at a concourse of scientific men of all nations, such as the one to which I have the honor, with great deference, to present this communication.

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THE POSSIBILITY OF OVERCOMING PERMANENT STRICTURE OF  
THE DEEP URETHRA WITHOUT RESORT TO EXTERNAL  
URETHROTOMY.<sup>1</sup>

BY

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WHEN selecting the above title for a paper to be read before this learned body, I had no intention to imply that doubt existed in the minds of any present that so-called permanent strictures having their seat in the deep urethra could be frequently relieved without resort to external urethrotomy. My object was rather to induce, by a recital of my own experience, in a few particular instances, a free interchange of enlightened opinion by skilled authorities in the line of this special surgical necessity, and so hope to learn from each their several skillful methods of achieving successful results.

To determine by the usual methods of examination whether or not a deep stricture requires surgical interference for its relief cannot by any means be regarded an ordinarily easy matter. I opine that all present will promptly indorse my asser-

<sup>1</sup> Read before the Eighth Annual Meeting of the American Association of Genito-Urinary Surgeons, Washington, D. C., May 29-June 1, 1894.

tion when I declare that a distinct and positive diagnosis in every case is rarely possible until every prefatory obstruction in the anterior urethra has been detected and wholly removed. I use the term *wholly removed* in its fullest sense and advisedly, because a number of instances have occurred in my experience, when, having reason to doubt the genuineness of the deep obstruction, I have deferred perineal section, and when a sufficient time had elapsed after meatotomy alone, or associated with internal urethrotomy, I have been gratified to find that what had seemed to be an impassable stricture in the deeper portion of the urethra, yielded readily to the passage of an instrument of a full size, according to Otis' correlative scale. Experience has repeatedly demonstrated that large-sized sounds have been immediately admitted along the entire urethral tract after the simple division of the meatus, when previously, an attempt to introduce the smallest filiform bougie met with unyielding resistance. This fact proves the possible existence of spasm in that part of the urethra especially prone to such phenomena, and doubtless gave rise to the term spasmodic stricture, the existence of which many authors have denied. I think this manifestation of reflex influence proves, and is now too generally accepted to admit of any doubt, the possible existence of an uncomplicated local spasm along the urethral canal, due to causes of remote character, and if such is admitted we must also recognize the possibility of a continuance of urethral erethism; especially in certain cases, for a considerable period after the immediate causes of reflected irritation have been removed.

To defer perineal section, when meatotomy and internal urethrotomy have been performed, and failed to facilitate the introduction of a sound to the bladder might be considered by some an unsafe proceeding; but experience will dispel this apprehension, as it has, on many occasions, in my own practice.

In a paper read before this Association at its Fourth Annual Meeting, June, 1890, Dr. E. R. Palmer<sup>1</sup> very satisfactorily, to my mind, illustrated this very fact with a citation of twenty-two cases of successful operation for bulbo-membranous close stricture by internal urethrotomy. Dr. Palmer will agree with me, however, in considering internal incision of strictures in the deep urethra not altogether free from danger; and although he is to be congratulated upon the number of successful operations

<sup>1</sup> JOURNAL CUTANEOUS AND GENITO-URINARY DISEASES, July, 1890.



he has performed of this character, we cannot withhold admiration of his skill and boldness. I must, however, place myself on record as disapproving of any attempt to remove by internal urethrotomy strictures located in the bulbo-membranous urethra.

The character of the lesion, always associated with some degree of spasm, is such that it may be overcome by patient dilatation after the remote causes of spasmodic contraction have been removed by appropriate treatment.

The following cases, which have been recently under my care, will exemplify the views I desire to maintain on this subject; though they are by no means all of the cases I could adduce which have been successfully treated in the manner to be indicated.

*Case I.*—G. S., in robust health, had for some time experienced much difficulty in micturition. He had frequent desire to pass water, which function was always accompanied by much vesical and urethral tenesmus, severe supra-pubic pain, as well as pain at the meatus and escape of urine *guttatim* for some time after urination was effected. A gleety discharge proved a source of annoyance. Lumbar and scrotal pain, headache and vertigo, so frequently associated with this disorder, also proved aggravating symptoms. The urine was slightly albuminous, but this was traced to the presence of a vesical catarrh which was not of recent origin. Retention had resulted once, before examination; the penis measured in circumference three and three-quarter inches; the meatus admitted only a bougie à boule of 20 F. The meatus, the patient informed me, had been incised several years before I was consulted; but it had been evidently timidly performed, for so narrow an orifice would not have probably resulted, if the incision had been boldly executed and reasonable effort made to prevent the cut surfaces from reuniting. The operator, however, may not be wholly responsible for this latter result, as I have on some occasions performed the operation to the necessary extent, and though the patients have continued to visit me a few times subsequently for the purpose of dilating the orifice, the relief which the operation afforded was so marked that they discontinued their visits, and were quite satisfied to take the chances of the result in their own hands with consequences similar to the one I am relating. A 20 F. sound was passed, with cocaine anesthesia of the urethra, as far as the bulbo-membranous junction, where much sensitiveness was complained of, and further progress of

the instrument was arrested. Smaller sounds were in turn tested, but the most careful and patient coaxing failed to overcome the stricture. Finally a filiform bougie was tried, and met with no better success. When about to desist making further effort I managed with careful coaxing to cause it to pass the obstruction into the bladder. Over this I passed, with no little trouble, a small tunneled sound, which was very firmly held at the seat of stricture ; and when it was withdrawn some hemorrhage followed.

By this evidence of spasm I concluded, from previous experience, the deep stricture was probably so aggravated by reflected irritation due to the contracted meatus, that if this was divided to admit the fullest-sized sound, equal to the capacity of the normal urethra, I would, by its introduction, overcome the spasm ; and by occasionally repeating this treatment finally cause absorption of the exudate at the seat of lesion, and in this way overcome the deep stricture. Meatotomy was accordingly performed, and though a 36 F. sound was readily passed down to the bulbo-membranous junction, its further progress was not permitted. I then tried smaller sounds, but not succeeding in introducing any beyond the original seat of obstruction, and considering it unwise to subject the patient to further instrumentation, I left him with the injunction to urinate in a sitz bath of quite warm water when he had the inclination to do so. Urination under these circumstances was effected with slight hemorrhage. The next day a large-sized sound was introduced as far as the membranous urethra, but not being readily admitted beyond this point no further instrumentation was attempted. Urination, after this, was effected without difficulty ; though I advised that the function be promoted and assisted, by the warm sitz bath, at least twice daily. On the third day after the operation I introduced a small sound, followed by two of larger size, to the bladder.

On the fifth day, commencing with a 28 F. sound, I successively passed without the least resistance sounds of larger calibre ; and finally 36 F. was introduced, followed by no hemorrhage or irritation whatever. The meatus was kept dilated, and 36 F. was passed once a week for three weeks, then once in two weeks on two occasions, once in four weeks for two or three times, when all symptoms of which the patient had complained were relieved.

*Case II.*—M. K., directed to me by Dr. L. L. Bradshaw, in 1892, had for some time complained of frequent desire to mic-

urate, followed by severe vesical tenesmus, with sharp pain extending from the lumbar region around the pelvis, down into the scrotum, and at the meatus urinarius. Urine continued to be emitted *guttatim* after micturition. A chronic gleet was a source of annoyance, and the patient has had retention requiring catheterization. Upon examination, strictures of large calibre were located at several points in the pendulous urethra, and the meatus admitted a 28 F. bulbous bougie. The circumference of the penis measured three and one-half inches. Upon the first examination it was impossible to introduce the finest filiform bougie. Before arrangements could be made to operate, the patient had retention of urine, for the relief of which I was summoned. With the greatest difficulty, and after prolonged and patient effort, the finest filiform bougie was coaxed into the bladder, over which, with no little difficulty, a small silver catheter of my own design, which I here take pleasure in showing, was directed into the bladder. The retention was thus relieved; but the patient was seized with a violent chill and some hemorrhage also followed on withdrawal of the instruments. An attack of acute rheumatism ensued, and all further interference with the urethra was necessarily abandoned. The patient, however, succeeded in urinating with sufficient ease during this interval of illness, by immersing the penis in warm water. At this time the indications for external urethrotomy appeared urgent, but on account of the rheumatic attack could not be entertained. Upon recovery the symptoms referable to deep stricture recurred, and another exploration of the urethral tract was undertaken with the same result as before, the deep urethra resisting all instrumentation. Fortified by previous experiences, I determined to incise fully the meatus, after cocainizing the entire pendulous urethra. The meatus was therefore divided to admit a 34 F. bulbous sound, then 24 F., 26 F., and 28 F. sounds were successively introduced along the entire urethral track. No undue effects resulted. On the 3d day after the operation a full-sized 34 F. sound was with facility introduced to the bladder.

I have had considerable experience in the treatment of spasmodic strictures as well as other forms of stricture, and am confident that the conditions present in the cases referred to were not wholly due to spasm; though to such a degree as is ordinarily met with, this element undoubtedly complicated in a measure the organic lesion which actually existed. Spasm always complicates strictures of the urethra, not only at the seat

of stricture, but is particularly reflected to the membranous portion with or without the presence of an organic lesion at this point.

The above cases afford striking illustrations of the fact I wish to establish: that a deep stricture, undoubtedly organic, existed; ordinarily an external urethrotomy might have been thought necessary, and possibly performed; that the spasmodic element, always present to a greater or less degree in deep organic stricture, often tends to obscure the judgment of the examining surgeon as to the possibility of overcoming it through less grave procedure than external urethrotomy, and that when a deep organic stricture, non-traumatic, is present, thorough and skillful removal of obstructions in the anterior urethra affords the surgeon every opportunity to relieve it by careful dilatation with graduated sounds; since the anatomy of the structure of the deep urethra is such that it yields more readily to dilatation, and absorption is more likely to result in this location from judicious and well-directed pressure by the sound. Incision at this point is apt to result in cicatricial formations, which is very apt to necessitate at some future time another operation for the relief of the symptoms which apparently made the first operation a necessity.

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#### ORIGIN OF SYPHILIS IN ANCIENT AMERICA.<sup>1</sup>

BY

ALBERT S. ASHMEAD, M.D.,

New York.

Late Foreign Medical Director, Tokio Hospital, Tokio, Japan.

I BEG to present to science the following facts, which bear directly on American racial origins. In an article which I published in the *Medical News* in 1891 I asserted that as it was highly probable, from certain facts which I enumerated in the same article, that the American races were descendants of the East Asiatics, it was no less probable that syphilis existed in America many centuries before the advent of the Spaniards. For this disease, without doubt, was known in Japan as early as the seventh century at least. In another article published in the *Journal of the American Medical Association*,

<sup>1</sup> Communicated to the Medical Society of the State of Washington, Annual Meeting, 1894.



April, 1892, I declare that but three positions can be taken in regard to the presence of syphilis in America. 1st. It existed before Columbus, being autochthonous. 2d. It existed before Columbus, being brought from East Asia. 3d. It was introduced by Columbus. Brenton, Brühl, Jones, etc., think that it existed before Columbus, therefore one of the first two propositions is true. I further show that when East Asiatic syphilis, that is, the syphilis of Japan, was inoculated in virgin European blood it produced a type as malignant as that which was transferred by Columbus from the ancient races of America to Europe, it is reasonable to suppose that the disease in both situations, "pre-Columbian America, East Asia had the same degree of attenuation," that is, by repeated inoculations it has developed an equal measure of immunity in both situations. This I consider as one of the facts which militates powerfully for the blood relationship of America and Eastern Asia.

I added to these considerations some archaeological facts.

These two articles have been recently republished in the *Tei-I-Kwai Medical Journal* of Tokio.

In an article which appeared in the *Journal of the American Medical Association*, February 3, 1894, I refer to the antiquity of syphilis in Japan and China, showing that the disease certainly existed in the Chu dynasty, that it was introduced into Japan, where it landed in the southern district, probably Nagasaki.

I insisted upon another fact, that is that the disease in China and Japan came from the South, and that the most ancient American races had come from the North, probably from the Behring sea; therefore the disease was not autochthonous here, that it was probably migratory with the races themselves. Here is another point in favor of the relation of East Asiatics and Americans.

Recently, in science, Mr. Farnsworth gave some evidences of a Japanese connection with the Vancouver Indians, and connected the Alaska and Vancouver Indians with Central America and Mexico. It must be noted our first knowledge of American syphilis is derived from these last countries.

In a quite recent communication of Judge Wickersham, (Tacoma, Washington) the mound builders of Ohio and Tennessee are directly connected with our northwestern parts. In Ohio and Tennessee mound builders the evidences of syphilis are undeniable.

Considering, therefore, the extreme antiquity of this disease

in East Asia, and the great probability of its journey from the North to the South in America, its direction in the second case being exactly the opposite of its progression on the other side of the Pacific, we must conclude that an autochthonous syphilis in America is out of the question; for if it arose in the wet and heat of Southern China it would be very unlikely to have an origin quite contrary in our own country. The route from Behring sea is alone admissible.

Judge Wickersham writes me as follows: "If the natives of East Asia were afflicted with this disease in pre-Columbian days, there is no question of its probable journey to America, for we have records of hundreds of Japanese wrecks on this coast—one of undoubted authenticity on the shores of this State (Washington) in 1833. It seems," he adds, "that our ethnologists are coming to the theory of the Asiatic origin of our Indians very fast. I do not see how they could do otherwise."

Let me add a few facts which have seemed to me to be of importance for the comprehension of the subject.

The Ainos could not have been the progenitors of our ancient races; they are out of the question. Now, in Japan the most famous mountain is that of Fujiyama. Until very recent years the name of that mountain has been interpreted in Chinese. Yama means mountain in Japanese, but no philological light could be thrown on Fuji. The Japanese have always supposed it to mean, in Chinese, not two, that is, peerless. This explanation is evidently somewhat violent. Some Japanese scholars have very reasonably observed that as the mountain was named Fuji long before the Chinese invaded the islands it could not have a Chinese origin. They therefore tried the Aino language for and pronounced Hudji, found a natural explanation of it; Hudji, means man of fire. The Fujiyama is a volcano.

There are many names in Japan of Aino origin, geographical names. Wakasa is a province rich in springs; Wokasa is the Aino name of a water spring. We may also quote Yeddo, which means plain.

Judge Wickersham has sent me his report as to the ancient naming of Mount Tacoma,<sup>1</sup> in his State. Suppose some ancient Japanese had arrived on that coast by a shipwreck, and under any other circumstance, what name would they have been likely to give to that mountain, which must of necessity strike

<sup>1</sup> Proceedings of the Tacoma Academy of Science, Tacoma, Washington, 1893. Paper by Hon. James Wickersham, "Is it Mount Tacoma or Rainier?"

them as being remarkably like their own Fuji. Bear in mind, that if the Japanese were the fathers of our ancient races, they came here before Buddhism had invaded their islands, before a holy character had been attached to Fuji, and that the meaning of the Aino name of that mountain was certainly unknown to them, otherwise they would have handed down that meaning. They would most likely call it the high mountain Takaiyama, pronounced Takyomma.

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A SIMPLE DEVICE TO FACILITATE MICTURITION IN PATIENTS  
WITH ARTIFICIAL SUPRA-PUBIC URETHRÆ.

BY

G. FRANK LYDSTON, M.D.,

Chicago, Ill.

IT is a quite common experience that patients with supra-pubic fistulæ complain bitterly of the difficulty of avoiding soiling the clothing during micturition *via* the artificial urethra. In patients who have control over the urine by virtue of a pseudo-sphincteric action of the vesical opening I have been able to add to the patient's comfort by a very simple device. The patient is furnished with a small glass funnel. When the desire to micturate comes he presses the funnel end of the apparatus against the supra-pubic opening and is thereby enabled to project the outflowing stream quite clear of his body and into a suitable receptacle. By pressing a small pad of absorbent cotton against the pubes below the funnel with his free hand, what little excess of urine may flow from the funnel as it is removed at the completion of the act may be caught by the patient. My patients become sufficiently adept in the use of this simple device to absolutely avoid wetting themselves during micturition. I trust that other surgeons may obtain as much satisfaction from the procedure as I have done. Anything which will lessen the complaints of this most troublesome class of patients should be welcome to anyone who has to deal with them.

## Society Transactions.

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### AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

EIGHTH ANNUAL MEETING, HELD AT WASHINGTON, D. C., MAY 29, 30,  
31 AND JUNE 1, 1894.

DR. GEORGE CHISMORE, *President, in the Chair.*

*(Continued from page 309.)*

**Aero-Urethroscopy with a New Instrument.**—By DR. WILLIAM K. OTIS, of New York.

The instrument consists of a hard rubber disk backed with metal, one and three-quarter inches in diameter, identical with the Klotz tube. In the center of this disk is a circular aperture, one-half inch in diameter, to the anterior edge of which is soldered a metal rim, one-quarter inch deep, which serves as the main portion of a sliding joint by means of which tubes of various sizes and weights are attached. A glass diaphragm, held in the metal collar and placed at an oblique angle to prevent the reflection of light, is arranged on a pivot so as to swing over the aperture, hermetically closing it; or, when desired, instrumental applications through the tube beneath may be made by simply swinging it to the opposite direction. A slight projection on the side of this cap locks under a metal shoulder, by means of which the illuminator is fastened to the plate in exactly the same manner as to the Klotz tube. A small metal tube extends from the edge of the plate into the movable cap. To the outer end is fastened a short length of rubber tubing with two India-rubber bulbs, like those used with the Paquelin cautery, by means of which the inflation is produced. Tubes of any length or calibre may be used with this instrument. If one is the possessor of a condensed air apparatus the rubber bulbs may be advantageously dispensed with.

The speaker said that while aero-urethroscopy will no doubt often render a diagnosis possible in obscure cases, our methods are still very imperfect. The escape of air into the bladder is disagreeable to the patient. The view obtained of the urethra is hazy and unsatisfactory, and for the purpose of making topical applications the urethral speculum is equally as good. Aero-urethroscopy will probably never supplant the methods heretofore in use.

DR. OTIS also exhibited an instrument which he devised for the purpose of facilitating catheterization of the male ureters. In this instrument the prisms are so arranged that a better view of the mouths of the ureters may be obtained than by the older instruments.

DR. BELFIELD showed an instrument which he devised for the purpose of securing a view of the deep urethra. The lamp is placed at the farther end of the instrument, as in the Leiter cystoscope, and the window at the curve of the beak. The lamp is surrounded by plaster-of-Paris, to prevent the end of the instrument from becoming heated. He also showed another instrument essentially the same as the first, but longer, so that it can be used in the bladder. A lens is screwed into its outer end, which prevents



the escape of air. Before introducing it the bladder should be completely emptied and then inflated with air through the catheter. By means of this instrument a good view is obtained of the bladder in the region of the trigone.

DR. OTIS, in reply to a question, said that by means of the hand-bulbs sufficient pressure is constantly applied to keep the urethra distended. He regarded Dr. Belfield's instrument as a very ingenious one, and thought that its use would greatly facilitate catheterization of the male ureters.

**New Instruments and Apparatus.**—DR. F. TILDEN BROWN, of New York, exhibited a perineal tube-holder. The holder is intended for cases in which long-continued drainage of the bladder by means of the perineal tube is indicated.

DR. BROWN also exhibited a needle-holder for Hagadorn needles. By means of a spring in the handle of the instrument needles of any size are firmly held. He also exhibited a modification of the Clover crutch for perineal operations. In this apparatus the leg pieces are held apart by a right-angled cross-piece instead of a straight bar, and it is thus well out of the way of the operator. By means of a spring the cross-piece can be shortened or lengthened at pleasure.

DR. BRYSON said he has found that the best drainage tube for the bladder through the perineum is one made of soft rubber, with an eye similar to that in the Bigelow evacuating tube. It is not likely to become blocked and gives little trouble.

**Stone in the Bladder. Choice of Operation.**<sup>1</sup>—By DR. WILLIAM H. HINGSTON, of Montreal.

DR. CHISMORE said that the general character of Dr. Hingston's paper is such that it commends itself to the intelligence of everybody. He would only refer to one or two points brought up by the author. In cases where we find the bladder stretched, cap-like, over the enlarged prostate a small stone may evade every possible instrument which we can introduce through the perineal incision. The fact of its being a small stone may be the very reason why we are unable to seize it. It may be hidden away in some pocket of the bladder wall. Dr. Chismore said he has never encountered a stone of over one thousand grains. Calculi nowadays do not seem to attain the size they did in former years. This is probably due to the fact that patients seek relief earlier now than they did formerly. When a large stone is seized with the lithotrite a little manœuvring will sometimes enable us to crush it, which otherwise would not be possible. After pressing the jaws of the instrument together as firmly as you dare, by waiting a moment you may feel the stone crushing under the spring of the steel. Another little manœuver that may prove useful when you are unable to crush the stone is to grasp it away from the center and try to split off a corner; the remainder will be less resisting.

DR. POST, of Boston, said that during the past year he had a patient under his care for stone who was also affected with hip disease from childhood. On account of the position of the limbs it was impossible to get him into the litholapaxy position, nor could he be operated on through the perineum. The bladder was accordingly opened above the pubes. Considera-

<sup>1</sup> Will be published.

ble difficulty was experienced during the operation, owing to the adherent peritoneum.

DR. BANGS called attention to the fact that removal of the stone is often only the first step in the treatment of these cases. In choosing our method of operating it may be necessary to select one of the cutting operations, so that the bladder and the pelvis of the kidney may be properly drained. In some patients the recurrence of stone is so prompt and frequent that they may be properly spoken of as having the "stone disease."

DR. JUDKINS, of Cincinnati, exhibited a calculus weighing ninety-five grains, removed through a supra-pubic opening. The patient was a child aged seven years, who suffered from the "stone disease." Two days after the operation pneumonia set in, and during a fit of coughing one of the stitches of the wound was torn out. This left a fistulous opening through which urine escaped for some time. Four or five weeks ago the child's mother came to Dr. Judkins with the stitch which had been torn out; it had been passed through the urethra and was thickly covered with phosphatic deposits.

DR. WATSON said he was glad to see that Dr. Hingston favored lithotripsy. The class of cases referred to by Dr. Post, in which the peritoneum is adherent, is not very infrequent. Dr. Watson also referred to the statistics presented by Dr. Chismore in connection with his paper read on the previous day, and his phenomenal results obtained by the crushing operation.

DR. BRYSON said it has always appeared to him that litholapaxy is the proper operation to choose in these cases wherever it offered any particular advantages. When he departed from this rule he did so on account of the condition of the bladder, or in cases where there was a predisposition to stone formation. He has operated in a number of cases where the stone rested behind the prostate, which obstructed the outflow of the urine and set up a cystitis; in two of those cases he was afterward compelled to do a cutting operation, the distinct object in view being to remove the obstruction which produced the cystitis, and which resulted in the formation of secondary calculi.

DR. HINGSTON then closed the discussion. He said he is not wedded to any particular method of operating. He expressed the opinion that there is no condition of the kidney in which lithotripsy is not as good or a better operation than lithotomy. There is no disease of the bladder in which lithotripsy is not a better operation than lithotomy. He does not care what the condition of the urine is, whether loaded with pus or not. The source of the trouble is the stone and it should be removed. The cutting operation should be confined to cases in which we cannot possibly lithotripsy. As regards the redevelopment of stone, there is no more danger of this after lithotripsy than after lithotomy.

**Urine-Leakage and Stricture Formation.**—By DR. J. P. BRYSON, of St. Louis.

In his paper the author made a comparative study of the histology of stricture of the urethra and that of old urinary fistula, and illustrated the same with a number of drawings of microscopical sections. His conclusions were as follows:

1. The close resemblance in the tissue elements, their arrangement and

effects upon the related normal structures, point to an identity of the etiological factor, and give support to the doctrine of urine-leakage.

2. Observing the prolongation of the urethra epithelium on the fistula wall in an effort to create an adequate artificial channel for urine, and seeing that the epithelium lining the stricture also participates in the battle against urine-leakage, we may take fresh hope of radically curing strictures, even of the pendulous urethra, by such means as tend to restore or rehabilitate the urethral lining.

3. Merely diverting the stream of urine for a time, without such restoration of the lining mucous membrane, would fall into the category of palliative treatment along with urethrotomy and the various methods of dilatation.

DR. R. W. TAYLOR, of New York, said that the title of inflammatory stricture can only be applied to cases where we have a round-celled infiltration in a still lingering state of congestion and inflammation: beyond that we get the period of fibrosis or stricture formation. The inflammatory stage of a stricture is that during which exudation is present. He did not agree with Dr. Bryson's statement that it is only the fixed cells which form the fibrous tissue. It has been shown that these small round cells become developed into fibrous tissue. The further formation of stricture is due to the continual development of small round cells into connective-tissue cells. The pathological appearance of these conditions hardly warrants the theory of urine-leakage suggested in the paper, which thus far must be regarded as pure assumption. In fibrous strictures of even the worst form the tendency is to become covered with stratified epithelium; the cylindrical epithelium is lost in the gonorrhœal process and is replaced by squamous epithelium. Neither the appearance of the epithelium nor of these fibrous cells gives any indication that there is continual urine-leakage.

DR. BRYSON said that he did not contend that the doctrine of urine-leakage was definitely settled. He simply presented his paper as a comparative study on the subject. Most of the authors who have written on the pathology of stricture have confined themselves to what he would call the inflammatory stricture. They leave out the so-called cicatricial form, due to traumatism, etc. When urine is brought in contact with tissues not adequately covered with epithelium the stricture formation begins. Wherever this fibrous tissue is formed we see it begin apparently just as soon as the urine is brought in contact with the uncovered tissues. Furthermore, we see that these stricture walls undergo involution and atrophy.

DR. TAYLOR said that where the stricture tissue is not covered with epithelium there is more or less superficial ulceration. This is shut off by a zone of round cells, which is an effort on the part of nature to dam it up.

**The Possibility of Overcoming Permanent Stricture of the Deep Urethra without Resort to External Urethrotomy.**<sup>1</sup>—By DR. J. BLAKE WHITE, of New York.

DR. TAYLOR said that spasm of the *compressor urethræ* muscle is a great bugbear. It is assumed that this muscle is in a continual state of great tonicity. As a matter of fact this is not so, and in the great majority of cases a soft catheter can be passed into the posterior urethra without any trouble. As a result of inflammation in the anterior urethra the compressor muscle undoubtedly contracts, and this constitutes spasmodic stricture.

<sup>1</sup> See p. 339.

It is possible that some of the spasm in Dr. White's case was due to instrumentation.

DR. MARTIN said he was glad to learn that there are still surgeons who believe that stricture can be cured by other means than the knife. In one case under his observation the patient had such a tight urethral stricture that a perineal fistula formed. This closed, and the man had retention of urine. After several hours' work Dr. Martin succeeded in passing a filiform bougie into the bladder. He then proceeded to dilate until the urethra admitted a No. 12 (French) sound. The man disappeared, and when he returned six weeks later the calibre of the stricture had again become so small that only a filiform bougie could be passed. It was again dilated to No. 30 (French), and since then the man has had no further trouble.

DR. WATSON said that while he was not in favor of the divulsion of strictures in the deep urethra he did not know where the idea originated that the operation was attended by a high mortality rate. He thought that one per cent. was the highest mortality rate reported.

DR. W. K. OTIS said that both Sir Henry Thompson and others abandoned the operation because of the high mortality.

DR. TAYLOR said that Van Buren and F. N. Otis gave it up for the same reason.

DR. BRYSON said it appeared to him a very difficult thing to entirely separate the two methods of treating stricture, namely, cutting and dilatation. The process of dilatation is a most rational and scientific one in dealing with any stricture that is amenable to that form of treatment. As a matter of fact very few strictures will fail to yield to gradual, intermittent dilatation. Certainly the mere division of the stricture does not accomplish anything. As regards spasm of the urethra, the speaker said he was perfectly in accord with the statements made by Dr. Taylor. From this cause he has never experienced any serious trouble. Dr. Keyes has very graphically described the so-called soft strictures which break down and disappear before any form of dilating instrument. They are apt to bleed a good deal. In those cases, the rational explanation is that they are made up chiefly of cellular infiltration and are of recent origin; Dr. Bryson showed a drawing of a fibrous stricture which is undergoing inflammatory atrophy brought about by continuous dilatation.

DR. HINGSTON said the discussion of Dr. White's paper at least justified the conclusion that the treatment of strictures of the urethra has not yet been settled. There was a time when no man dared to divide a stricture or employ force in its dilation. He is of the opinion that Dr. F. N. Otis has come very near to the correct solution of the problem in his method of gentle dilatation with occasional division. No two strictures are exactly alike. While gradual dilatation will do in one case, it will not do in another. The element of time must be taken into consideration. In the treatment of so-called cartilaginous stricture, through which we are unable to pass a sound beyond a certain size, he thought the best and most permanent results obtained by gentle stretching with division.

DR. F. TILDEN BROWN said that Dr. White in his paper has presented us with a very clear-cut type of cases. He did not see why such conditions of spasm, or partly spasm and partly cellular infiltration, should be regarded as the outcome of instrumentation. A number of cases that have come under his observation, in which external urethrotomy for deep stricture was



about to be performed, and after dividing the strictures in the anterior canal it was found that full-sized instruments were easily passed into the bladder.

DR. W. K. OTIS said that while there is no doubt that most strictures can be dilated to a certain point, there are cases, like that of Dr. Martin, for instance, in which cutting would give more permanent benefit. In that case the stricture will probably re-form. When a stricture is relieved by cutting, the patient is not obliged to pass a sound on himself all his lifetime, and subject himself every time he does so to the danger of a certain amount of sepsis. As regards spasmodic stricture, he has seen many such cases which he does not think were due to instrumentation.

DR. BRYSON said that in the cicatricial form of stricture located in the deep urethra he has in some cases thoroughly divided them and then passed instruments for a long time, and yet there was a rather prompt return of the obstruction.

DR. WHITE, in closing the discussion said he was positive that in the case reported by him the spasmodic stricture could not be attributed to instrumentation.

**Exfoliation of the Mucous and Submucous Coats of the Bladder, Preceded by Renal and Vesical Calculus.**<sup>1</sup> By DR. ALEXANDER W. STEIN, of New York.

DR. BRYSON said it is possible that in exfoliative cystitis we may have the early stages of the condition referred to by Dr. Stein. He has never seen a case in which the entire mucous membrane of the bladder was shed.

**A Plea for the Excision of the Initial Lesion.**—By DR. EDMUND E. KING, of Toronto, Canada. (Read by the Secretary.)

The author stated that while the specific microbe of syphilis has not yet been isolated it is almost beyond doubt that the disease is caused by a specific germ. In all germ diseases there is a period of incubation of variable length. In a good many the effect of the germs is self-limited, while in others it is continuous. That mild cases of these diseases occur proves either that a smaller dose of the germs was administered or that the soil was not properly suitable for its growth, or that both of these conditions existed together. In all cases we have a period of incubation, of exacerbation and a period of recrudescence. The intensity of secondary syphilis has been held to be in direct proportion to the extent of the initial lesion; this the author said he has corroborated, and he has further demonstrated clearly to himself that it is also in direct proportion to the *time* that the initial lesion has existed.

DR. KING said he does not think it is possible by any known means to abort syphilis, once the germ, in sufficient quantity, has entered the general system, but that the course of the disease can be greatly modified by limiting the amount of the poison which enters the economy. Excision has been useful in other diseases where fatal results follow the introduction of a poison, when neglected; for instance, the effects of rabies and the bite of a cobra have been prevented by free and early excision. So, with syphilis, if it is possible to see the lesion during the first few hours of its existence and to at once excise it the disease may be aborted. Even with the ameliorat-

<sup>1</sup> See Page 273.

ing results, the patients should not be allowed to be careless about internal treatment.

**Epithelioma of the Penis.**<sup>1</sup>—By DR. EDWARD MARTIN, of Philadelphia.

DR. BANGS said he was entirely in accord with the statements made by Dr. Martin. He was much interested in the *resumé* of the literature in regard to the contagion of epithelioma of the penis contained in the paper.

DR. TAYLOR said that epithelioma of the penis occurring in syphilitic subjects is probably a coincidence, as we usually see it after the syphilitic processes have ceased. He has seen quite a number of these cases, and it has always appeared to him that where the epitheliomatous process occurred in an old syphilitic scar the latter was the seat of an irritation which led to the cancerous process.

DR. LEWIS inquired whether in these cases, where amputation of the penis is performed, it is well to remove the testes also? This has been advocated by some on the theory that if they are left the rubbing of the clothing against the stump of the penis produces a certain amount of erythema, and increases the supply of blood to the parts, thus favoring recurrence.

DR. J. BLAKE WHITE said he desired to emphasize the value of the suggestion made by Dr. Martin in regard to the microscopic examination of the tissues about the periphery of the stump after amputation. In that way we can learn whether there is any extension of the disease beyond what appears to be its limit.

DR. CHISHOLM said that last July a typical case of epithelioma of the penis with involvement of the inguinal glands came under his observation. He made a partial excision of the cancerous mass, and six weeks later the glands in the groin were removed. The man has about one-third of his penis left. Up to the present time there has been no recurrence. The glands in the groin clearly showed cancerous infiltration. Partial excision in epithelioma of the cervix seems to have given as good results as complete hysterectomy.

DR. MARTIN, in closing the discussion, said he thought removal of the testes was advisable in cases where total extirpation of the penis was performed, but not where there was only partial excision. The question of the contagiousness of the disease is still *sub judice*. Many cases have been reported in which only partial excision was performed, and no recurrence took place. Still, he favored radical treatment from the start.

**Inflammation of the Seminal Vesicles.**—DR. ROBERT W. TAYLOR, of New York, read a paper with this title.

This affection, which is also known as seminal vesiculitis, may be acute or chronic. The acute form has many points of analogy with epididymitis. Both affections are almost always secondary to gonorrhœa, occurring in the third or fourth week, or to hyperæmia of the posterior urethra due to masturbation and venereal excesses, or to inflammation of this region resulting from traumatism, catheterization, endoscopy and strong injections. The symptoms of the acute form of seminal vesiculitis are quite similar to those of posterior urethritis, and to those given as diagnostic of the several vari-

<sup>1</sup> Will be published.

eties of prostatitis. The patient first experiences pain, either of a dull or throbbing character, or a sensation of weight, which he refers to the deep portion of the pelvis just within the anus or at the neck of the bladder, or in the perineum. There is marked increased frequency in urination, and tenesmus, sometimes mild, again quite decided, and in some cases very severe. As the bladder fills, the painful symptoms increase in severity, and there may be pain at the end and sometimes at the root of the penis. There may be fever, chills and malaise. All these symptoms may be present in posterior urethritis, so that the crucial test in diagnosis is palpation of the prostate and seminal vesicles by means of the finger in the rectum. If the case is one of acute posterior urethritis the prostate will be tender, even painful on pressure and perhaps swollen. If seminal vesiculitis is present and explored for early, one or both vesicles will be found to be much enlarged in all directions in the shape of a distended leech, hot, brawny and exquisitely tender. Defecation is very painful and perhaps complicated with rectal tenesmus, and may be attended with vesical spasms; sleep is heavy and unrefreshing, and often during the night painful erections, perhaps bloody, may add to the patient's sufferings. In a few days the swelling may still further increase and then moderate fluctuation may be felt.

The chronic form of seminal vesiculitis may result from the non-occurrence of resolution in the acute affection, and in this form the clinical history is tolerably clear and striking. But in the majority of cases it begins as a low-grade inflammatory process, in persons particularly of neurotic type, who may suffer from chronic or sub-acute posterior urethritis or chronic prostatitis, and in confirmed masturbators, and in those given to excessive venery and alcoholics.

As regards prognosis: In the acute form of this trouble resolution usually takes place. In the chronic form amelioration and cure may be obtained. In some cases, however, the morbid process goes on to the formation of large tumors, which require operative interference.

*Treatment.*—When recognized in the acute stage seminal vesiculitis is to be treated on the general principles which govern the management of all phlegmasiæ of the genital and urinary organs. A good plan is to apply a large number of leeches upon the perineum and the margin of the anus. Injections of cold water may be used and the rectum may be packed with ice if the procedure is pleasant to the patient. Opium in suppositories, diluents and saline cathartics may be administered as required. Should an abscess form it may be reached by means of a long incision in the perineum, just anterior to the anus. The resulting cavity should be treated on general surgical principles. When the abscess is not large, but well defined, it may be aspirated through the rectum. In more acute and extensive abscesses, free incision through the rectal wall, followed by careful antiseptic packing, has been recommended.

In the treatment of chronic seminal vesiculitis, in which we may find distended, pouchy vesicles, much stress has recently been laid by Dr. E. Fuller upon what he terms stripping or milking the vesicles with the finger tip, which is inserted in the rectum. Dr. Taylor said it is no easy matter in many cases to reach the vesicles with the finger, and to clearly define their size and shape. Moreover, the seminal vesicles are made up of blind ended tubes or diverticula, and for anatomical reasons it will be clearly seen that the utmost that can be accomplished by stripping or milking a vesicle is to

act upon about one-quarter of its whole structure. The author said he had no doubt that the ampullation of the vas deferens, which is so commonly near the prostate, has often been mistaken for enlargement of the seminal vesicles.

DR. GARDNER W. ALLEN said that in the cases of seminal vesiculitis that have come under his observation the symptoms were not characteristic, and a diagnosis could only be made by a rectal examination. In the cases of cystitis referred to in his paper (read on the previous day) the patients had marked symptoms referable to the neck of the bladder, and the seminal vesicles were doubtless involved. In spite of the anatomical demonstration made by Dr. Taylor to illustrate how difficult it would be to express the contents of the vesicles, Dr. Allen said he thought he had succeeded in reducing the size of the organs in these cases by pressure with the finger exerted through the rectum.

DR. MARTIN said that for some time past he has been in the habit of searching for the seminal vesicles in cases of epididymitis, orchitis, etc. He is of the opinion that in apparently few cases of epididymitis is there any evidence of swelling about the vesicles. In healthy men he has not been able to locate them at all. Dr. Martin exhibited a number of diagrams showing inflammatory conditions of the vesicles. In three of these cases the symptoms were those of posterior urethritis; the pain seemed to be referred to the hip and the outer surface of the thigh on the corresponding side. In the treatment of these cases his results have not been very flattering. Theoretically, milking or stripping the vesicles will not accomplish a cure, because, as Dr. Taylor has shown, we cannot reach the upper border of the vesicle. His best results have been obtained by hygienic measures and long-continued hot rectal injections.

DR. GEORGE E. BREWER, of New York, said that one symptom of chronic vesiculitis which was not mentioned is frequent ejaculation on very slight provocation; the fluid ejaculated coagulates rapidly, forming a jelly-like mass. As regards expressing the contents of the vesicles with the finger, Dr. Taylor's demonstration is conclusive that the opening of the larger portion of the vesicle is above the point which we are able to reach; there is no question in his mind, however, that by this means he has been able to squeeze out some of the contents of the vesicles. It is not inconceivable that when these sacs are over-distended simple pressure will cause some of their contents to exude. We may not be able to empty them absolutely.

DR. JAMES R. HAYDEN, of New York, said that in many cases of epididymitis and orcho-epididymitis examined by him he was unable to locate the seminal vesicles. In cases where they were involved attempts at milking them had proven very disappointing.

DR. BANGS said he has not been able to outline the seminal vesicles positively, excepting in chronic cases. In such instances, by making pressure through the rectum, he has been able to express a fluid which contained spermatoc elements. Whether this came from the ampullated part of the vas deferens or from the seminal vesicles he did not know. By stripping we may be able to empty the occluded tubes; it is doubtful whether we can exert much pressure on the inflamed sac itself.

DR. ROBERT F. WEIR, of New York, said it is only of late years that much attention has been given by surgeons to these acute conditions affect-



ing the seminal vesicles. He is of the opinion that many of the obscure conditions of the upper part of the bladder may be explained by the presence of these abscesses in the vesico-prostatic region. Such abscesses can be best reached by incision in the perineum.

He has in a number of instances removed the seminal vesicles for tubercular disease, together with the testis and vas deferens.

DR. BELFIELD called attention to the fact that there is another mucous-lined cavity in the deep urethra which is of interest in connection with this subject, namely, the sinus pocularis. We are inclined to look upon this as insignificant, and yet it is a fact that it varies extremely in size. It is located in the urethra between the upper lobes of the prostate, and when distended it forms a swelling in the region of the seminal vesicles. It is a question whether this may not be involved where there is trouble in the seminal vesicles.

DR. BRYSON said he was greatly interested in the anatomical demonstration made by Dr. Taylor. He thinks there is some danger of mistaking chronic inflammation of the seminal vesicles for tubercular inflammation. There is one class of symptoms which he is accustomed to ascribe to seminal engorgement, and which he has relieved by emptying the distended portion of the seminal apparatus, and that is, the symptomatology which closely resembles what was formerly regarded as being due to irritable ulcer or fissure of the anus. It is generally found in elderly men who are high livers, and who have a prostate that is somewhat enlarged. Such a patient may wake up at night with a severe pain about the anus at the top of the sacrum. In some cases the pain is quite constant.

DR. TAYLOR then closed the discussion. He said it is a difficult matter to locate the seminal vesicles in many cases. When they are inflamed and distended pressure in that region would be apt to produce rupture of their wall: nothing heroic in that direction therefore should be attempted. In the majority of cases it is probably the ampulla that is manipulated through the rectum and not the vesicles themselves.

**The Question of Surgical Interference in Tuberculous Kidney.**<sup>1</sup>—By DR. JOHN P. BRYSON, of St. Louis.

DR. BANGS stated that after a good deal of experimentation in this class of cases he has come to the conclusion that good hygiene is the chief, if not the only factor in the cure of tuberculosis. If we can get them to go to Southern California, or anywhere else where they will enjoy the benefit of an even, invigorating climate, we stimulate the action of the skin and thus relieve the kidneys. He was glad to hear Dr. Bryson refer to those cases of latent vesical tuberculosis which are rendered acute, often dangerously so, by unnecessary instrumentation. The general health of these patients is far below par, and any traumatism, be it ever so slight, may convert the process from a latent into an active one. In tuberculosis of the bladder Dr. Bangs said he confined himself to very gentle ameliorating therapeutic measures. In some of these cases the cystoscope revealed a peculiar pulpy red condition at the base of the bladder; this he has observed so often that he has come to regard it as significant of tuberculosis, even if the bacilli are absent.

DR. KEYES said that in these cases of tuberculosis of the kidney he is

<sup>1</sup> Will be published.

of the opinion that the surgeon should either stand aside or else play the physician and only operate when emergency demands it. The local manifestations of a general disease like tuberculosis are apt to be so numerous that it is a mistake to be over-zealous with the use of the knife. General hygiene is very important in the treatment of these cases. As regards the pulpy condition of the mucous membrane of the bladder in the region of the trigone, referred to by Dr. Bangs, the speaker said he has observed it a number of times. It is purplish red in color, and bleeds readily. He has seen it, not only in tuberculosis, but also in cases of double pyelitis, where the base of the bladder is constantly bathed in pus.

DR. BELFIELD said he thoroughly believes in non-interference in tuberculosis of the genito-urinary organs. Out of seven cases in which he undertook operative measures only one resulted satisfactorily; in that case the patient had tuberculosis of the prostate and epididymis on the left side, and there was strong evidence that the kidney on that side was also implicated. The man suffered from very frequent micturition, and on draining the kidney the intervals of urination were lengthened to five or six hours, and the man felt so much improved that he was able to perform his usual duties. He ultimately died of general tuberculosis.

DR. BILL said that in cases where the tubercular lesions were limited to the bladder and prostatic region he has had very satisfactory results from opening the bladder above the pubes and then instituting prolonged drainage after cauterizing the diseased area. Where the lesions are very diffuse we of course cannot expect to get permanent benefit by operative interference.

DR. CHISMORE said he long ago became very conservative as regards the use of instruments in tuberculous patients, particularly as regards washing out the bladder in cases where one of the chief symptoms is frequent micturition. This is apt to be followed by a serious explosion of the disease.

**A Case of Cystitis and Pyonephrosis due to Colon Bacillus, requiring Nephrectomy.**<sup>1</sup> By DR. F. TILDEN BROWN, of New York.

*(To be concluded.)*

## THE NEW YORK DERMATOLOGICAL SOCIETY.

### 232D REGULAR MEETING.

DR. C. W. ALLEN, *President, in the Chair.*

**A Case of Hereditary Syphilis, with a Generalized Papulo-Squamous Eruption.**—Presented by DR. JOHN A. FORDYCE.

The patient was a child about one year old. The mother states she has had no other children and no miscarriages. This child was healthy and well nourished at birth, and remained so until three weeks ago, when this eruption appeared.

**A Case of Ulcerating Nævus of the Vulva.**—Presented by DR. C. W. ALLEN.

The patient was a female child, aged four months. She was referred to

<sup>1</sup> Will be published.

him in November, 1893, by Dr. George E. Swinburne, and presented an ulcer occupying the lower half of the right labium majus. The lesion was crater-shaped, with an uneven base, and covered with a dirty, sloughing membrane. A red margin surrounded its lower edge, and on close inspection it was found that the seat of the ulceration was a congenital nævus. Simple remedies were first employed, until the ulcer had cicatrized, and later electrolysis, under the use of which the lesion has decreased in size.

DR. FORDYCE considered the situation of the nævus a very unusual one; he advised puncturing with a fine-pointed galvano-cautery wire to produce destruction of the vessels. Electrolysis would probably not be successful.

DRS. ELLIOT and SHERWELL stated that cavernous nævi were not materially affected by electrolysis, on account of the large size of the vessels. The thermo-cautery would be necessary to destroy them.

DR. JACKSON said that electrolysis would cure a cavernous nævus only over bony prominences, not in soft tissue like the lip or vulva. A large nævus of the forehead under his treatment was entirely shrunk up by electrolysis.

DR. R. W. TAYLOR stated that many years ago he saw a large nævus of the vulva cured by means of a shoemaker's awl, heated to white-heat, and thrust into the margin of the growth.

DR. S. LUSTGARTEN said that while it is quite possible that such a lesion as this could be cured by electrolysis, which is a method of cauterization, he thought it better for cosmetic reasons to refer such cases to the surgeon for operative interference.

DR. ALLEN said that in this case the nævus extended into the vagina, and an operation might give rise to permanent narrowing of the ostium vagina. He said that ten years ago he had cured a cavernous nævus extending to both surfaces of the lip, by means of electrolysis.

DR. TAYLOR said he did not think the excision of the nævus in Dr. Allen's case would cause much involvement of the vagina.

**A Case for Diagnosis.**—Presented by DR. H. G. KLOTZ. The patient was a man 69 years old. Two years ago a small lesion appeared on the right hip, in the trochanteric region, which within a year increased to the size of a fifty cent piece and then became stationary. When the man first came under observation the lesion was covered with firmly adherent brownish scales. The lesion has been covered with a 10 per cent. salicylic acid plaster for about four weeks. Since then the margin of the patch, which was sharply defined, has become less so. The surface now presents a number of small, cup-shaped openings, into which a probe can be passed for a short distance. The man complains of pain in the right leg and in the patch itself.

DR. LUSTGARTEN said that clinically the lesion resembles tuberculosis verrucosa. He did not care to venture a positive diagnosis without a microscopical examination.

DRS. CUTLER and JACKSON regarded the case as one of tuberculosis of the skin; the latter had observed a case very similar to this both in location and shape.

DR. FORDYCE considered the case as one probably of tuberculosis of the skin—possibly lupus erythematosus.

DR. KLOTZ stated that the surface of the lesion was in no way verrucous; he was positive that the pus foci or abscesses had not existed at any time since he saw the case, to account for the openings. He was inclined to regard the case as one of lupus erythematosus.

**A Case of Eczema Seborrhoicum Showing the Result of External Treatment.**—Presented by DR. G. T. ELLIOT. The case was the one which was shown by Dr. Sherwell at the last meeting of the Society. Dr. Elliot said he presented him simply to show the marked improvement after four weeks' treatment by external application alone, viz, a 10 per cent. rhubarb ointment on the leg and 5 per cent. dermolin-resorcin salve on the body, without any "training" or internal medication. The affected area on the chest had lost its thickened character and its definite outline; its color was now a pale red and its extent was much reduced. On the leg only moderate weeping existed in places, itching and pain had ceased, the inflammation was much less and the œdema gone.

DR. SHERWELL complimented Dr. Elliot on the results obtained in the lesions upon the head and upper part of the trunk. He looked upon these, however, as entirely different in character from those on the leg, which, though somewhat improved, were in his opinion very far from being cured, and, he still thought, would be found very intractable to external applications alone. While under his care the man had been an ambulant dispensary patient, with—owing to different circumstances—irregular attendance. His chief object in sending the patient to the hospital was to obtain for him the intelligent daily care, which he had indeed received. He believed even now that depletory and constitutional treatment would be of great benefit. The lesions above had yielded before to resorcin and salicylic acid, but the leg had resisted these remedies and others, though decided benefit had been obtained at times.

DR. CUTLER had not doubted that the case could be cured by rest and appropriate local treatment, but feared a speedy recurrence as soon as the patient would leave the hospital.

DR. JACKSON said that the improvement would have been still more pronounced had dietetic treatment and exercise been combined with the external applications.

DR. FORDYCE had been unable to obtain good results from rhubarb ointment in eczema of the face and scalp, certainly not as good ones as from resorcin.

DR. LUSTGARTEN found the improvement a decided one for four weeks.

DR. KLOTZ said that there was probably present underneath the lesions of the leg what he had described as "dermatitis hæmostatica," and even if the eczema was cured the skin would remain thickened.

DR. ELLIOT said he regarded seborrhœic eczema as a purely parasitic form of catarrhal dermatitis. In over sixteen hundred cases of the disease which had come under his care he had never seen any of them influenced to the slightest extent by internal treatment, or by diet, or by exercise, or by anything excepting such local remedies as destroyed the micro-organisms. He could not see any sense in treating skin diseases by a method of dieting which was applied to every case regardless of its etiology or pathology. Errors in diet, either quantitative or qualitative, should be corrected.



but if dieting was needed the condition of the patient should furnish the indications in every single case.

In regard to the recurrence of eczema, Dr. Elliot said that skin diseases were governed by the same laws of general pathology as other diseases, it was natural therefore that the disease should be liable to return whenever the predisposing and existing conditions came into existence again. He blamed dermatologists for inculcating in the minds of the laity the idea that a cutaneous eruption once gotten well should never return, and if it did had not been properly cured. The patients thought it was natural, however, to have, under proper conditions, repeated attacks of bronchitis, diarrhœa, etc.

**A Case of Lupus Vulgaris.**—Presented by DR. ELLIOT.

The patient was a male, aged 23, a native of Germany. He has resided in this country only a few months. Family history negative. When the patient was two years of age this lesion appeared on the dorsum of the right hand, which in spite of manifold treatment has steadily progressed. At the present time the disease extends on the dorsum of the hand from the knuckles of the index and middle fingers and thumb upward over the wrist for a distance of an inch and one-half. Its broadest diameter is about one to two inches, and its margins are irregular in outline. The distinctive features of the disease have been considerably obscured by irritating applications, but the tubercles can be recognized and also the areas of cicatricial tissue. On the flexor surface of the wrist is a serpiginous outline formed by a linear arrangement of pinhead sized tubercles. There are similar patches on the dorsum of the left hand and on the back of the neck.

**A Case of Syphilis.**—Presented by DR. LUSTGARTEN for DR. PIFFARD. The patient was a medical student who, about one year ago, had a sore on the lip followed by glandular enlargements in the sub-maxillary region. About eight weeks ago gumma-like lesions appeared on the face and neck. The case was probably one of syphilis, although the lesions failed to yield so far to specific treatment.

DRS. JACKSON, TAYLOR, FORDYCE and others regarded the case as one of syphilis.

**A Case of Probable Pityriasis Rubra** (Hebra).—Presented by DR. ELLIOT.

The patient was a man aged 66, a native of Canada, a sailor by profession, but lately engaged as a 'longshoreman'. He first came under observation in January, 1892. He was well preserved, of slight but wiry build, and strong. Family history negative. No alcoholic history; had gonorrhœa many times; never had syphilis.

About three years ago the man had a diffuse redness on the chest, which in a month progressed over the entire body; it was accompanied by great burning and itching, and much scaliness. These symptoms subsided in about six months, and a period of quiescence ensued, which was broken four months before he came under observation by a new attack similar to the first one, but more persistent. The major part of the cutaneous changes were on the upper part of the body, occupying the chest and back, the abdomen, the axillæ and the extensor surfaces of the arms. The lower extremities were very slightly affected. The symptoms consisted of a diffuse

redness and scaliness. There was slight thickening of the skin and some infiltration. The flexibility of the skin was not impaired. The scales came off easily for the most part, but in many places they were adherent. No vesicles or papules or weeping areas. No œdema. In the inguinal regions and in the axillæ there were bunches of enlarged glands, which were soft and doughy and painless. Enlarged glands were also felt along the borders of the large pectoral muscles, and immediately beneath the right nipple was a nut-sized tumor. The glands were all freely movable.

A provisional diagnosis of erythrodermia was made and a 2 per cent. salicylic acid ointment prescribed, with an alkaline mixture for internal use. In the Autumn of 1892 a gradual subsidence of all the above symptoms occurred, and the man was comparatively free from trouble until the latter part of 1893, when he had an outbreak of redness and scaling which gradually covered the entire body. The redness was intense, the scaling marked and the itching severe. The legs and feet were swollen. In February, 1894, the man entered the Skin and Cancer Hospital, where he has since remained. The glandular enlargements have returned in the inguinal, axillary and pectoral regions. In addition, subcutaneous, doughy, somewhat lobulated tumors, from the size of a pea to a nut, can be felt on various parts of the body.

DRS. CUTLER, FORDYCE, JACKSON, BRONSON, LUSTGARTEN and SHERWELL stated that they considered the case as one of pityriasis rubra.

DR. JACKSON mentioned that in a very bad case of dermatitis exfoliativa in a child the treatment by linseed oil baths had resulted in remarkable improvement, and, strangely enough, with the improvement of the skin there was noticeable a marked improvement in the child's intelligence.

DR. LUSTGARTEN suggested a careful examination of the thyroid gland and the employment of thyroid extracts if indicated.

DR. SHERWELL confirmed the soothing and beneficial effects of the linseed-oil bath, and referred to a case observed by himself.

DR. ELLIOT, in closing the discussion, said he was not surprised to see thickening of the skin in the case presented, as that occurs in the first stages of the disease. This man, up to last September, was comparatively free from trouble. Two years ago he had an erythrodermia, which entirely disappeared. The atrophic condition of the skin and the thickening of the nails and other appendages appear in the later stages. The microscopical examination of one of the tumors mentioned had so far only showed fatty tissue.

**A Case of Keratosis Follicularis Contagiosa of Brooke: Acne Cornée of the French.—Presented by Dr. ELLIOT.**

The patient was a male, aged 14 years, a native of Russia; family history negative; no specific nor tubercular antecedents. The patient first came under observation in February, 1894. He presented an eruption which he has had for four and one-half years. It began upon the upper portion of the back and gradually spread, and at present it covers to some extent the face, the trunk and the extremities. The lesions are for the most part discretely distributed, but in some places they are aggregated and form quite large areas. They are pinhead in size, but also larger, slightly elevated papules, of a pale or darker red color, containing in their

centers a dark, hard, adherent plug, which, when forcibly removed, leaves a depressed pit, surrounded by a minute circular wall of infiltration. No ulceration is seen, though there is slight bleeding when the crust is removed. On the backs of the hands are large, pea-sized, fleshy papules, dark red in color, bearing upon their central portions brown or greenish crusts, which are firmly adherent and occupy more or less shallow pits, the bases of which are apparently slightly warty. There are no pronounced spines or horny prolongations. Besides these lesions over the trunk, neck, limbs and backs of hands there are large and small irregularly shaped and round or oval scars, which are attributed to "sores" occurring about eighteen months ago. There are no evidences of vesicular formations. The patient suffers in no way from the cutaneous process beyond itching, especially at night.

**A Case for Diagnosis.**—Presented by DR. G. T. JACKSON, on behalf of DR. FOX.

The patient was a Chinaman, who, in the early part of January, 1894, had a number of red patches appear on the body. Since then the redness has disappeared to a considerable extent, and left brown patches. The lesions are disseminated over the entire body. There is more or less pruritus. The man had resided for a time in the West Indies.

DRS. ALLEN, BRONSON, FORDYCE, ELLIOT, LUSTGARTEN and SHERWELL made the diagnosis of leprosy, Drs. Bronson and Fordyce leaving it in some doubt, the former stating that the lesions were not very characteristic of leprosy. Dr. Fordyce thought that the pigmented spots were the remnants of primary erythematous lesions. The man had no anæsthesia or any other nerve lesion. Dr. Lustgarten called attention to the superficial infiltration which developed in the center of the lesions and gradually became diffused.

DR. JACKSON said he was in doubt himself about the diagnosis. Apart from the nationality of the patient he would not have thought of leprosy.

**A Case of Psoriasis.**—Presented by DR. A. R. ROBINSON.

The patient was a man aged 50. The lesions were distributed over the whole body, but were much more numerous upon the neck than elsewhere. There were probably two hundred lesions upon the neck and many upon the face. Those on the body very closely resembled lesions of eczema seborrhoicum and were widely separated and comparatively few in number. He presented the case on account of this peculiar distribution, he never having seen or heard of a case of psoriasis having so many lesions upon the face and neck.

DR. ALLEN referred to a case of syphilis now under his observation, in which the lesions, especially the serpiginous patches, were very similar to those of psoriasis, having the same kind of scales and acting alike under scraping. They get well under mercury, and leave behind a brownish pigmentation, which psoriasis, as a rule, does not.

DR. SHERWELL said that the psoriatic and pseudo-psoriatic lesions occurring during lactation are often very difficult to differentiate. The fact that psoriasis usually appears on certain regions of the body should be borne in mind.

DR. ELLIOT said he has seen a number of cases of squamous syphilide

in which the lesions very closely resembled psoriasis. If we regard the desquamation alone it is very easy to make a mistake. While psoriatic lesions do not leave pigmented spots, such pigmentation may appear if the case is being treated with arsenic.

DR. FORDYCE said he recently saw a case in which dark pigmented spots appeared on the face and the mucous membrane inside of the lips, as the result of arsenic administration.

DR. JACKSON had recently observed a case of psoriasis with a distribution of the lesions almost as remarkable as in Dr. Robinson's case. In one case of syphilis he had seen the lesions strongly resemble those of psoriasis.

DR. KLOTZ pointed to the absence of desquamation in the lesions on the chest and their strong likeness to seborrhœal eczema.

DR. LUSTGARTEN suggested that the accumulation of lesions on the neck of the patient might be due to some irritating application, a wet dressing, etc.

DR. ALLEN exhibited the *picture of a burn on a woman's heel*, which was produced by the application of a hot-water bag to the foot five weeks ago, while the patient was under the influence of ether. The burn extended through the entire thickness of the cutis and the subcutaneous cellular tissue down to and into the fat. An extensive slough was removed. He asked the opinion of the members as to the treatment of the wound, whether it would be better to allow it to cicatrize or apply skin grafts?

DR. ROBINSON said he recently saw a case in which a burn of the heel was made by a hot-water bag two years ago. The cicatrix is still so sensitive that the patient is unable to wear a shoe.

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## Book Reviews.

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*Traitement des Rétrécissements par l'Electrolyse Linéaire.* Par le DR. J. A. FORT. Paris, 1894. G. Masson, Editeur.

This work of Dr. Fort, which consists of a volume of 550 pages, largely illustrated by clinical histories, advocates in a forcible manner the author's treatment, by means of the electric blade and strong currents, for stricture of the urethra and œsophagus. The author claims for his method, the details of which have already been presented to the profession, a superiority over the older procedure by means of the knife, divulsion, etc. The form of treatment by weak currents, known as the Newman's method, is also considered of little worth. Among the advantages claimed by its author for the so-called linear electrolysis are a decreased constitutional reaction, rapidity, precision, little or no hæmorrhage and permanency in result. In fact, the picture presented in advocacy of this method is most rosy and attractive, and if the general profession can accomplish like results there is a probable future for this form of electrolysis. The profession at large, however, has in the past been led to expect so much from various forms of electrolyses for the cure of stricture, only in the end to be grievously disap-



pointed, that Dr. Fort's work, in this country, at least, naturally meets with a reception somewhat sceptical. Still, as it is rumored that the author will shortly come to this country to practically demonstrate his ideas, it is only fair for the reader to reserve his opinion of the method till such time. Then, however, before expecting approval, Dr. Fort should be called upon to refute the conclusions arrived at regarding his procedure by Dr. E. Desnos, of Paris, in the August, 1893, number of the *Annal. des Maladies des Organ. Génito-Urinaires*, a review of which article has recently appeared in this Journal.

EUGENE FULLER.

*Traité Clinique de Dermatologie.* (A Clinical Treatise on Dermatology.

Par le Dr. H. Tenneson, Médecin de l'hôpital Saint Louis Paris.)  
Octav Doin, Editeur, 8 Place de L'Odéon.

This work is a résumé of the author's clinical instruction at the Saint Louis Hospital, and as a careful and truthful reflection of his teachings is of much interest to his colleagues wherever they may be. The order of subjects is such as we should expect, that is to say, there is no order at all. It is as though we were given a lecture to-day on eczema because the necessary number of interesting cases to furnish his inspiration had presented themselves. To-morrow he takes up prurigo for the same reason, and the next day lichen, and then *la Pelade*. At least, it comes in somewhere along in due course, and it is treated with that same degree of familiarity which French authors so often show in writing upon the various forms of alopecia. The chapter begins "*La Pelade est aussi manifestement contagieuse que la rougeole et les oreillons.*" In a subdivision Pseudo-Pelades are discussed and the form *à cheveux fragile* and that pointed out by Brocq are described.

Under the designation *Acné Pilaris* we find the description and appropriate treatment for what is here generally called Acne Varioliformis, and Bazin's term, *acné varioliforme*, is still retained for what the author admits is now generally called "*Molluscum Contagiosum de Bateman*," and then goes on to show that the term doesn't come from Bateman at all. The whole matter would be much simplified if French writers would adopt our plan of calling the disease by its plain, well-deserved name, "*Molluscum Contagiosum.*" A good account is given of the various adenomas, and Darier's *psorosperme folliculaire végétante* is made the fifth variety of the artificial group *acné sébacée concrète* and is dismissed with little discussion, it being considered an open question whether the observation made by Darier and others had to do with real psorosperms or with simple changes in epithelial cells.

An interesting observation is recorded on p. 110 of the frequent occurrence of polymorphous erythema in the course of secondary syphilis.

Tricophytosis receives consideration in a chapter of merited length, then after one on favus M. Berdal has been given nine pages in which to describe methods of examination for parasites in the tineas.

Toward the end of an interesting account of *balano-posthite érosive circinée* the condition is referred to as b. p. é. c., and this suggests an excellent plan which writers employing long-drawn-out designations might employ with advantage just as the modern chemist saves his time and ours by some such simple device as  $H_2O_2$ . I am sure that only one encountering the symbol d. p. p. r. d. l. g. would at once recognize the disease of our friend, Dr. Brocq, just as p. f. v. would suggest the name of Darier.

M. Tenneson has produced a very readable book, with an introduction which is scattered over with morsels of food for thought. The text, though not always full, touches upon almost every dermatological affection, while quite a lengthy chapter is devoted to the syphilides.

The arbitrary arrangement of the matter we can only consider more desirable than an attempt at classification at the present time, though possibly an alphabetic arrangement has some advantages. C. W. A.

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## Selections.

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**Further Researches on some Parasitic Protozoa found in Cancerous Tumors.** M. ARMAND RUFFER and H. G. PLIMMER. (*The Journal of Pathology and Bacteriology*, June and October, 1893.)

An abstract of Ruffer and Walker's first article, "On some Parasitic Protozoa found in Cancerous Tumors," will be found in the October number (1893) of this JOURNAL.

The present paper is an account of work pursued along the same lines in the light of increased experience, and in one variety of carcinoma, that found in the breast. It is divided for the sake of convenience and simplicity into four divisions.

The first installment in the June number is entirely occupied by Section I. and may be briefly summed up as follows: In cancer of the female breast some of the protozoa found therein inhabit the nucleus as well as the protoplasm of the cell. The protozoon appears generally as a small body in the nucleus, when it develops gradually until it exhibits the characteristics of a full-grown protozoon, remaining in the nucleus or escaping into the surrounding protoplasm. The characteristics of the parasite comprise, (1) a central, round, oval or slightly irregular nucleus, sometimes connected by delicate rays with the periphery; (2) a variable amount of protoplasm almost or entirely filling; (3) a double contoured capsule surrounding the whole. While occurring in the nucleus, they are found mainly in the protoplasm of the epithelial cell, a fact which may account for the failure of other observers to discover them in this situation.

Section II. is concerned with the structure of the parasite in the infected cell. The nucleus differs from the nuclei of the epithelial cells not only in structure but in its micro-chemical reactions. It stains with difficulty with the ordinary nuclear dyes, an aversion found also in other protozoa. To some extent, it reacts to aniline dyes like the nucleolus of the epithelial cell. A striking example of this is seen in specimens fixed in picric acid and stained with eosin and afterward aniline blue. On washing out with water the first structure to be seen is the nucleolus stained intensely with eosin, whereas the nucleus of the parasite remains blue. The nucleus is larger in living organisms than in those fixed in the various fluids. In fresh scrapings mounted in normal salt solution, the parasite can be made out lying in the infected cell and the nucleus appears as a vacuole, undergoing spontaneous

movements and changes of shape. When the protoplasm has shrunk within the capsule the rays already mentioned were not from the capsule but from the periphery of the protoplasm. As to the capsule itself, it is a part of the invading cell, not secreted by the host for its own protection, as can be demonstrated when the capsule shrinks in the interior of the epithelial cell. The protoplasm is quite homogeneous or else contains a few granules and the rays. The granules range themselves in a beautifully regular order near the periphery. The size varies from  $.004\mu$  to  $.04\mu$ .

The phenomena of division occupies Section III. The parasite of cancer, according to the author's observation, divides into two or multiples of two, the simple method being the more frequent. The nucleus elongates a little, then separates into two equal parts, a fissure appearing in the center and gradually deepening. The nuclei separate gradually but remain connected for some time by fine, delicate, granular threads. While the threads remain, the capsule begins to divide by a prolongation thrown out from either side and finally uniting in the center. Later, the threads disappear and the two protozoa become rounded off. In the multiple division, fragmentation of the nucleus takes place, the fragments arrange themselves at the periphery and a process of segmentation in the capsule completes the change. Each young parasite has its own capsule and leads an independent existence. No spore formation was ever observed.

Section IV. is given over to a discussion of the various structures described as parasites by other observers. Arnold, Müller, Delépine, Wickham, Malassez, Klebs and Steinhaus all come in for a share of the attention. Ruffer and Walker's previous paper is defended from the attacks made upon it by them, but the discussion is too long for review here. The paper is accompanied by a series of chromolithographic plates, quite up to the standard set in the first contribution, the perfection of the art.

JOHNSTON.

**A Case of Fibrinuria.** JAKSCH (*Archives Générales de Méd.*, April, 1893, p. 483) has observed in his service a case which he believes without parallel up to this time in medical literature, the elimination of fibrinous coagulations by the uropoëtic system not having been remarked except in renal tuberculosis and diphtheria. The patient is a man of 39 years, suffering from neither of these maladies, having neither hematuria nor chyluria, enjoying reasonably good health, who was suddenly taken on the 28th of April, 1892, with fever, violent lumbar pains, giving on palpation a sense of resistance in the region of the left kidney. The urine, of high specific gravity, contained albumin. In the first week of May the urine became ammoniacal, contained leucocytes, crystals of hæmatoidin, epithelial cells from the ureters and pelvis and remarkable long ramified fibrinous coagulations, preparations of which Jaksch presented. These various phenomena were of short duration; the fever and swelling disappeared; the fibrinuria ceased. Jaksch believes that in the present case there is, in the left kidney, an echinococcus vesicle, although the examination of the urine has never revealed the presence of the parasite. Still, the absence of the hooklets is not proof positive against this hypothetical diagnosis, for these hydatid cysts have often been found at the autopsy, without their presence having been revealed during life by the passage with the urine of any part of these parasites.

JOHNSTON.

## THERAPEUTIC NOTES.

**Treatment of Persistent Erythema.**—In cases of “erythematous affections which remain fixed upon the skin for weeks, months, or even years, without alteration of type,” J. F. PAYNE finds that the disease may be successfully combatted by certain drugs, and when the eruption betrays no tendency toward spontaneous resolution after the lapse of a considerable time, the indication for their use is a strong one. The agents which have given him the best results are quinine in large doses and sodium salicylate. The indications for each are not clear. Twenty to thirty grains of quinine in five-grain doses should be given daily. Sodium salicylate does not always give the best results in rheumatic subjects. The quinine was most satisfactory, but if, after a fair trial, it does not cause improvement, the salicylates should be substituted.

The local treatment has two ends in view: astringent as regards the blood-vessels and sedative as regards the nerves. Lead lotion meets the first, coal-tar, carbolic acid, etc., the second. Ointments are objectionable on the ground of their retention of the heat of the skin.

**Salicylic Acid in Xanthoma Multiplex.**—The disease, involving the patient's palms and fingers, interfered with the practice of his trade and treatment was directed to the relief of the tenderness. This lotion was directed to be painted on three or four times a day:

R		
Ac. Salicyl.	5 i	
Liq. Epispastici	m. xv	
Ol. Ricini	5 i	
Ether. Acet.	ad 5 i	
M.		

Some improvement resulted, both in reduction of size and tenderness of the tumors, but after a time it ceased and the application was changed as follows:

R		
Ac. Salicylici	5 i	
Chrysarobini	5 ss	
Ol. Ricini	5 ss	
Collodii flex.	ad 5 i	
M.		

The lesions and the sensitiveness entirely disappeared from the palms, but the tumors in other situations were not affected.

**Electrolysis in Acne Vulgaris.**—The same author used the current from a dry Lechlanché battery to remove indurated lesions left in the cheeks after thirteen years of the disease. The strength of the current did not exceed 3 miliampères, but the treatment must be repeated in case of large nodules. The needle connected with the negative pole should be inserted deep into the center of the induration. There was no return in the points treated and no resultant scarring. (*Brit. Jour. of Derm.*, May, 1894.)

JOHNSTON.



# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

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### THE PROTOZOA-LIKE BODIES OF HERPES ZOSTER: A CONTRIBUTION TO THE STUDY OF PSOROSPERMOSIS.<sup>1</sup>

BY

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THE pathological changes which occur in the skin in herpes zoster are described in text books upon dermatology, almost without exception, as similar to those found in other vesicular diseases; as, for example, eczema. It is the purpose of this paper to show the inexactness of this statement, and more particularly to call attention to certain bodies resembling more or less closely protozoa which are always to be found in the vesicles of zoster at a certain stage of their development. These structures are not present in the ordinary inflammations of the skin, but are peculiar to zoster, variola, vaccinia and varicella. They exist in such numbers and are so remarkable in appearance that it is difficult to understand how they have failed to attract the notice of those who have studied the pathological anatomy of the first-mentioned disease. Pfeiffer first accurately described them a few years ago, but his observations have received little or no attention. It should be added that, while this author first called attention

<sup>1</sup> Read at the Eighteenth Annual Meeting of the American Dermatological Association, Washington, D. C., May 31, 1894.

to them as occurring in zoster. Weigert had previously described, under the term coagulation necrosis, similar structures found by him in the pustules of variola. Pfeiffer rejects the notion that they are the result of pathological changes in the epithelial cells of the rete mucosum, and believes that they are parasites of the order of protozoa which, having gained access to the skin through the medium of the intercostal blood-vessels, produce the eruption characteristic of the disease. More recently Wasielewski,<sup>1</sup> who has collected a large number of cases, has joined the ranks of those who believe that zoster is an infection, and has expressed the opinion that it is due to these so-called protozoa, as Pfeiffer first suggested.

In the early stages of the eruption, before the lesions have reached their full development, these bodies exist only in small numbers; with the complete evolution of the vesicle they increase rapidly, forming a large part of the cellular elements present; but with the appearance of pus they can no longer be found.

For the sake of convenience in description they may be broadly divided into three varieties, which are tolerably distinct from one another, but are seen occurring together in the same vesicle.

The first variety, which is by far the most numerous, consists of perfectly round or slightly oval cells about the diameter of the polygonal cells of the rete, having a sharply defined, in most instances double-contoured wall, and one, or at most two, nuclei in the center. (*Vide* Figs. 3 and 4.) A considerable number of them are usually undergoing division, and in consequence their occurrence in pairs is frequently noticed. Their situation is usually at the bottom of the vesicle, forming a considerable part of its floor, and most abundant at the periphery.

In the midst of these round cells are seen the second variety scattered about irregularly, usually single, but occasionally joined together in pairs. These are much less numerous than the cells just described, but are enormous in size when compared with them, having a diameter three or four times greater than an ordinary epithelial cell. They consist of three distinct parts: (a) the cell body proper, a broad ring of tolerably uniform width without any external limiting membrane surrounding (b) a thick internal wall or capsule which in turn encloses (c) a large cavity in which are contained from three or four to a

<sup>1</sup> Correspondenz-Blättern des Allgemeinen Aerztlichen Vereins für Thüringen, Jahrgang, XXI., No. 5.

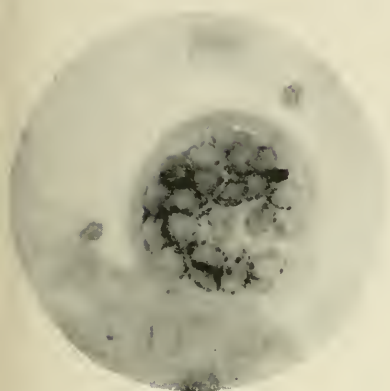


FIG. 1.

CELL RESEMBLING A SPOROCYST.

1/15 Homo. Im. A. oc.



FIG. 2.

SAME VARIETY OF CELL AS FIG. 1, BUT MUCH SMALLER.

1/15 Homo. Im. A. oc.

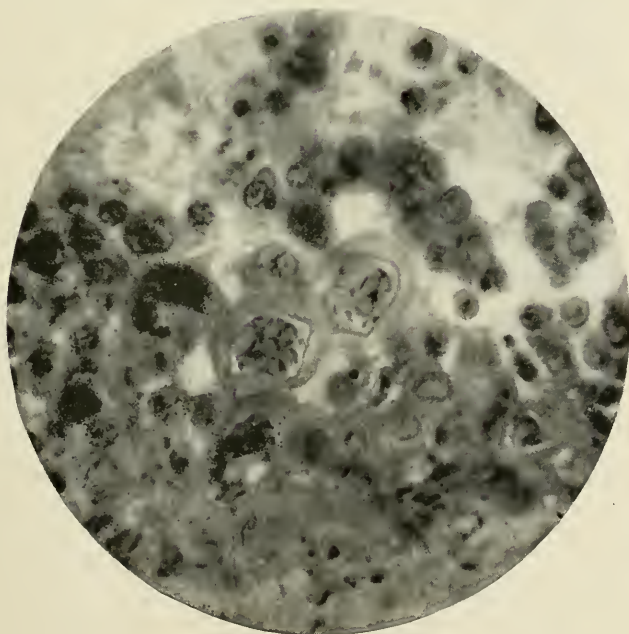


FIG. 3.

TWO CELLS OF THE SECOND VARIETY JOINED TOGETHER AND SURROUNDED BY NUMEROUS CELLS OF THE FIRST KIND.

1/15 Homo. Im. No. oc.

dozen or more round or oval cells. (*Vide* Figs. 1, 2 and 3.) These various parts show marked differences in their reaction to staining fluids; the cell-body stains much more feebly than other parts of the structure, carmine scarcely staining it at all, but the internal capsule and the cells contained within it stain intensely. Examined with a high power, still further details of structure become visible; the body of the cell shows a distinct but delicate irregular mesh-work, possibly produced by the action of fixing agents; the thick internal wall is found to be laminated, consisting of several layers, and the small cells contained in the central cavity are seen to be provided with round or oval nuclei and surrounded by a membrane which contains numerous small nodes arranged at regular intervals, which give it a peculiar dotted or beaded appearance. A further peculiarity is noticed in the fact that the nuclei of these small intra-capsular bodies stain rose-red with Biondi's fluid, instead of green, as is the case in the nuclei of ordinary cells. The entire structure bears a very close resemblance indeed to the sporocysts found in cases of epithelial cell infection in the kidney of certain snails and in beetles, as described by Pfeiffer. Certain minor variations from the form just described occur with considerable frequency. In some instances the internal cavity instead of being round is angular in shape, probably the result of external pressure, and the small cells contained therein instead of the beaded wall described above are surrounded by a membrane of uniform thickness. It should also be noted that in a few instances traces of structure resembling the prickles of the epithelium of the rete were observed.

The bodies of the third variety resemble in a general way those just described, but they have certain peculiarities of structure and more particularly of shape which entitle them to separate consideration. They are extremely large, pear-shaped and have the same arrangement of parts as the second kind; *i.e.*, a uniformly wide border surrounding an internal capsule which incloses a large cavity containing a number of round or oval cells. There is the same reticulation of the cell-body, but at the small end there is a protrusion of numerous delicate parallel fibers which appear to be continuous with the mesh-work of the body of the cell. The cells within the capsule are surrounded by an ordinary wall instead of the dotted membrane described above. The staining reactions are precisely the same as in the round cells; unlike these, however, they were never



found in pairs, but always single. They resemble in a striking degree the epithelial cells containing coccidia found in the bile ducts of rabbits suffering from psorospermiosis of the liver.

While the usual situation of these large round and pear-shaped structures is in the midst of the other cellular elements, occasionally they are seen lying in the cavity of the vesicle. In many instances some of the small bodies have fallen out of the capsule and are lying free. Pfeiffer found that these, when examined in the fresh and still living condition, exhibited amœ-

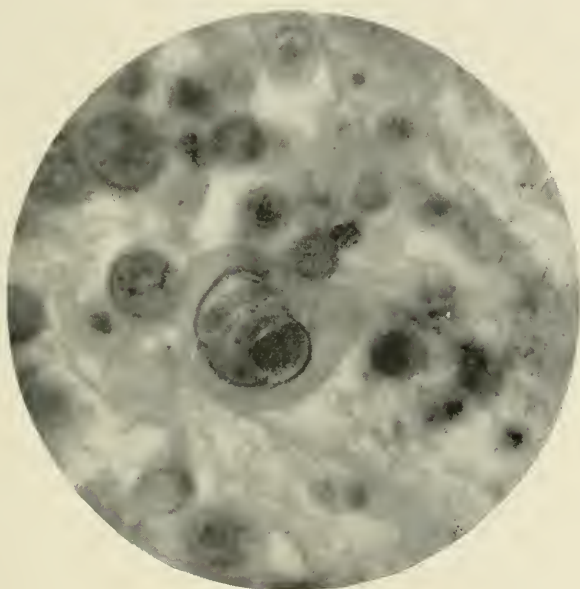


FIG. 4.

LARGE PEAR-SHAPED BODY—THE INTERNAL CAPSULE IS WELL MARKED.

1/15 Homo. Inn. A. oc.

boid movements which continued for some time, a fact to which we shall refer again.

The lesions in which these protozoa-like structures were observed were obtained from two cases of idiopathic dorso-pectoral zoster of the ordinary type.

Some years ago I had the opportunity to study carefully a case of recurrent zoster, which has been reported elsewhere,<sup>1</sup> the chief features of which were as follows: Severe neuralgic

<sup>1</sup> *Amer. Jour. Med. Sciences*, April, 1890

attacks in the course of the sciatic nerve recurring at short intervals for a period of one or two years, the first attack occurring a few months after the patient had suffered a compound fracture of the femur; a vesicular eruption over the sciatic nerve and its branches, differing in no respect from ordinary zoster accompanying these attacks of neuralgia after a year or two; recurrences at short intervals for ten or fifteen years. While studying the bodies which have just been described, it occurred to me that it would be of great interest to learn if similar structures were to be found in this case. Accordingly, the patient, who had long ago passed from my observation, was hunted up with the expenditure of a good deal of time and trouble, and, fortunately for my purpose, soon had one of his attacks of zoster, with a group of vesicles over the sacrum. One of these vesicles was excised and carefully examined microscopically. The alterations found were precisely the same as those in ordinary non-recurrent idiopathic zoster; there were the same large round and pear-shaped bodies already described, although they were comparatively few in number, probably because of the imperfect development of the lesion examined. All the clinical features of this case point to a traumatic origin and therefore exclude the possibility of an infection.

Since the peculiar cells which are present in the idiopathic form of zoster were likewise found here we may conclude with certainty that we have to do, not with protozoa, but with altered epithelium. And it is only fair to suppose that similar bodies present in some other diseases which are held to be psorosperms are in fact epithelial cells which have undergone a metamorphosis, the nature of which is still obscure. As is well known, hyaline degeneration has been invoked to explain these changes, but this leaves much to be accounted for. Pfeiffer, as has already been mentioned, observed active movements in these cells, a fact which argues strongly against the theory that they result from hyaline change. On the contrary, they show every evidence of being in a condition of active growth. That after they had reached a certain stage hyaline degeneration may occur is not denied; but the processes which produce their enormous growth and peculiar arrangement are certainly the result of vital activity, not of any degeneration, which must bring all growth to an end.

A CASE OF FAVUS OF THE HEAD AND BODY.<sup>1</sup>

BY

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AND

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ACCORDING to the statistics of the American Dermatological Association favus has been witnessed in 707 cases (one-third of one per cent.) out of 205,328 consecutive cases of diseases of the skin for the years 1877 to 1892 inclusive.<sup>2</sup> These figures show that the disease is rare in this country. It is met with, however, not infrequently among the lower classes of the recently arrived foreign element. The affection is much more common in wet and rainy cities. According to McCall Anderson, 118 cases occurred (in 6,451) in Glasgow. Purdon gives its frequency in the proportion of 14 in 3,000 in Belfast. Erasmus Wilson met with it in only three cases in 10,000, while Crocker saw only one in 2,000 in London. Thus it will be seen that favus is rare in England but common in Scotland. It is also frequently seen in France. (Feulard states that about one thousand conscripts yearly enjoy immunity from military service on account of favus.) It is very frequently met with in Poland, as well as in Italy, especially the southern part. Among the Jews—particularly the men—living in Russia, Poland, Hungary, Galicia and the Levant, and also among the Mohamedans living in Turkey, Asia Minor, Syria, Persia, Egypt, Algiers and Morocco, the disease is often encountered, and is attributed by Hirsch to the habit required by their religion of keeping the head constantly covered.

The disease, while usually affecting the scalp, may also occur upon any part of the body; although Charpy, as late as

<sup>1</sup> Read at the Eighteenth Annual Meeting of the American Dermatological Association, May 29, 1894, Washington, D. C.

<sup>2</sup> It would appear from a perusal of the literature of favus that the credit of discovering the fungus has been given to Schoenlein (1839), while in reality his observations were not completed until three years after Remak had discovered the fungus (1836). Later, the fungoid character of the disease was studied by Fuchs and Langenbeck, of Gottingen, and still later by Gruby of Vienna, who claimed not to have had any knowledge of the researches of Schoenlein.

the year 1874, mentions as one of the diagnostics of the affection that it is limited to the scalp, which is evidently an oversight, as Bateman, about 1818, in his original delineations of the affection (*porrigo lupinosa*) stated that he had witnessed the presence of favus upon the shoulders and upper portion of the back. Following this writer, Alibert, in 1825, also recorded cases occurring upon portions of the body other than the scalp. Rayet, in 1845, and Kleinhans, in 1864, had encountered favus on the face, while Pick, in 1869, considered the occurrence of favus on the glands and sulcus of the penis as very strong evidence against the almost general belief that it is confined to the hairy parts alone. Hebra, previous to 1873, had also observed the disease upon the palms of the hands and even on a stump after operation.

Horand says that the scalp is not the exclusive seat of the disease, and that he has often seen it on other portions of the skin. He states that when it occurs on the general surface it does not occur in disseminated cups, but very often in erythematous patches of varying sizes covered with scales. Bazin describes these erythematous patches as being circinate, their periphery being bordered with small vesicles or crusts (see cases by Havas, Anderson, Jackson and Pick), while the center seems nearly normal. These patches are very itchy, consequently it is easy to mistake them for *tinea circinata*. But if the case is followed up for some time the characteristic cups will be found to form around the hairs. Horand states that favus may appear upon the body and limbs without being on the scalp.

According to Kaposi, "not only may favus occur upon parts which are without hair, in the ordinary sense, that is, which have only fine lanugo hairs, but also on parts which have really no hair, but where there are follicles; and there is not a single spot, the glans penis, palm of the hand, or sole of the foot not excepted, on which favus has not been seen." "When favus is met with in parts without hair, especially on the trunk and extremities, it is generally accompanied by favus of the scalp. There is no doubt, however, that isolated patches of favus may arise independently on parts of the body mentioned, without the scalp showing, or ever having shown, any traces of the disease." (See case of Roddick, which had existed three years on non-hairy before attacking the hairy parts.)

The cicatrices which remain after the favic crust resemble those of syphilis, but are diagnosed from the latter by a fawn-



colored tinge, which rarely exists in the brownish scars of the latter disease.

The following case, which we are about to describe, is, we believe, according to the literature on the subject, the second one showing such extensive lesions which has been observed in this country, and it will be the eighth that has been reported:

John Janoni, born at Mundale, near Villini, Italy, March 24, 1883; his parents are living, and six brothers and three sisters, all older than he, are free from this affection. He first noticed the disease on shipboard, two days out, on his emigration to this country, two years ago. It began on his head, and did not spread to the body until five months ago.

Present condition (December 24, 1893): the patient, a rather tall boy for his age (10 years), measures five feet in height, and is fairly well nourished, weighing about 100 pounds. Owing to the boy's inability to speak English, and the Italian interpreter's slight acquaintance with that tongue, considerable difficulty was experienced in obtaining a good family history. The patient is a typical Italian in appearance, having the olive skin, dark hair and eyes peculiar to that race. There exists an ectropion of the lower lid of the right eye. On the head the disease affects the whole hairy portion of the scalp; on the apex, and in a circle of four inches radius about it, are decided atrophic scars, depressed, smooth, white and shiny. The whole head is covered with marked crusts, and while the lesions are elsewhere cup-shaped this formation is not so evident in the above-mentioned area. Other than on the above-mentioned locality the scalp is fairly well supplied with hair, one-half to one inch long, but dry, uneven, lustreless and brittle. The lymphatic glands of the neck, and in both axillæ, are quite enlarged; pediculi cannot be found on the scalp.

On the body the disease affects particularly the back and sides, the abdomen, chest, face, hands and feet being free from the disease. Careful examination of the nails on both hands showed them to be unaffected, and they presented a glossy, healthy appearance. The thickened, yellow, opaque and brittle condition of the nail substance, as noticed in cases of *tinea favosa unguium*, was entirely absent. On the back, a large patch, four inches broad, extends from near the spinal column on the left side, at the level of the sixth dorsal vertebra, up to the insertion of the posterior axillary fold. On the outer surface of each arm is a collection of lesions, two inches long, ending just above the external condyle of the humerus, that on



FIG. 1.  
FAVUS OF THE HEAD AND BODY.

the left arm extending slightly lower than the other. At the level of the tenth dorsal vertebra a patch begins on the right side of the back, and runs to about one and a half inches below the spine of the scapula, being about three and a half inches wide. There is a lesion, the size of a dime, near the acromion process; one the size of a half dollar near the inner end of the spine of the scapula, one the size of a dollar and another the size of a quarter-dollar near the spinal column, on the level of the seventh rib. In both lumbar regions there are nine scattered lesions, varying in size from half a pea to a lima bean; among these are some very perfect small crusts, elevated about a fourth of an inch from the surface, at the edge, rising with concentric rings from a pin-point erection in the center.

There are two circinate patches close together, on the upper part of the left buttock, each one and a half inches in diameter. About the left gluteal fold are scattered seven patches, varying in size from half a pea to a dollar. About half way down the left thigh are five patches, each from one inch to three inches in diameter, irregular in shape, together almost encircling the leg. On the outer side of the leg, just above the knee, is another, two and a half inches in diameter. From the right gluteal fold there extends downward a patch, irregular in outline, about five inches long and three inches broad. A small patch, the size of half a dollar, is just above the outer hamstring. On the lateral and anterior surface of the left leg there are five patches, running together, varying from half an inch to five inches in diameter. On the right leg a patch one and a half inches wide and four inches long runs from the middle line of the gastrocnemius (three inches below the popliteal space) downward and forward, and just below this is a separate patch as large as a half-dollar, in the median line of the leg. The front view of the patient shows, in addition to the parts of the above lesions that extend around, two half-dime sized patches on the right deltoid, and one in the middle of the left biceps, also two irregular small patches in the median line of the right thigh, half way down. The lesions are all small and covered with yellow crusts, resembling dried mortar, and for the most part cup shaped, and can be readily pulverized between the fingers. Where the crusts have been accidentally removed a reddened, rough, atrophic condition of the skin is revealed. On the right buttock, near the rima natium, an atrophic, roughened and depressed scar, marking the site of a former lesion, is seen. The mouse odor is very noticeable, even at some dis-

tance from the patient. A man in the venereal ward, on the same floor as the skin ward, contracted favus while our patient was in this department, although it could not be said positively that he had acquired it from him.

A portion of the crust taken from one of the lower legs was handed to Dr. David Bevan, whose report is herein included :

*Report of* DR. DAVID BEVAN: "I examined the crusts you sent me, and find that they consist of a dense interlacement of long, narrow filaments and small ovoid and spherical bodies, imbedded in a dessicated serum. On further investigation I believe these filaments to be the mycelia and hyphæ of the favus fungus, and the ovoid and spherical bodies their spores. In my investigations I made microscopic examinations of stained and unstained specimens, from the crusts, and also culture experiments. In every instance the diagnosis of favus was confirmed."

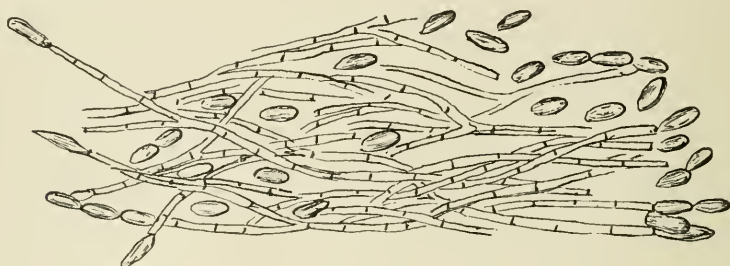


FIG. 2.

Of the cases affecting the non-hairy parts we have endeavored to collect as complete a list as possible, and from the literature at our disposal we have been enabled to include in this report fifty-four cases, which we propose to group as follows: *a*, those affecting the non-hairy parts of the body alone, and *b*, those located on the hairy and non-hairy portions.

Of the former variety, we note cases recorded by Bateman, about the year 1818, of which we cannot find the original report. In 1825 Alibert reported two cases, the one occurring in a man, æt. 30, in whom the lesions were present on the outer side of the thigh, the other in a girl aged 20, which involved different parts of the body. Rayer mentions the case of a man who presented a single but perfectly characteristic crust of favus on the outer side of one of his legs. This writer also quotes the case of a woman who was in the habit of carrying one of her



children affected with favus. After a time there developed on the fore-arm that supported the head of the child a small patch of favus. Rayer again refers to several remarkable cases of favus transmitted by contagion, published by Messrs. Mahon. Several other similar cases are likewise recorded in the *Journal Hebdomadaire*. Nine of the remaining cases affect portions of the face and are described below as follows:

H. Schiess-Gemuseus refers to a case affecting the upper eyelid, in a girl,  $\text{æt. 13}$ . The inner half of the upper eyelid was covered with a yellowish-white, dry crust, which extended below, somewhat over the internal marginal part and above the tarso-orbital fold. About the middle of the crust, between its superior and inferior margins, is a triangular crust which forms the entrance to a cavity about 3 mm. in depth.

Bulkley records four cases, one in a girl,  $\text{æt. 15}$ , in whom a hard, irregularly shaped, depressed mass existed under the left eye, one-third inch in length and one-fourth inch in width, surrounded by an inflammatory red border and suggesting nothing of the cupping spots of characteristic favus; taken between the fingers it felt hard and seemed to involve the entire structure of the skin. Later a patch resembling *tinea circinata* developed. The next case, almost identical with the preceding, was that of a man,  $\text{æt. 20}$ , in which the lesion was under the left eye, the crust showing the fungus. In a third case, a girl,  $\text{æt. 2}$ , the lesion was over the left eyebrow and presented but few of the characteristic cups.

The last case was that of a boy,  $\text{æt. 11}$ , in whom the lesions were noticed on the right cheek, near the chin, and consisted of a group of irregularly formed yellowish cups, like crusts, and having a margin of red and scaly surface surrounding them in an irregular circle for about an inch.

Two other cases were witnessed by Fink, who observed the disease, affecting only the cheek, in a boy  $\text{æt. 12}$ , and in another  $\text{æt. 7}$ .

Von Rossi records the case of a child, 7 years of age, who had a small spot on the right cheek which was crusted and very tenacious.

In a case reported by Derville he found a favic lesion on the forehead; a second lesion was situated on the level of the external angle of the right eye. There existed two red spots on the level of the neck; the lesions did not present the same appearance. The eruption on the forehead was formed of seven or eight cups and the form was characteristic, despite the co-

alescence ; that on the external angle of the right eye was grayish in color. There existed under the chin a rounded patch of very red color, and showing fine, slightly adherent desquamation on the surface ; the lesions were the size of a franc piece. The fourth lesion was situated on the right half of the neck.

Four other cases affecting the upper part of the thorax are recorded, one by Kaposi, occurring in a boy, in whom there existed thirty spots on the anterior and posterior part of the thorax, resembling herpes tonsurans, ranging in size from a lentil to a penny. In the center of several of these were favic scutula the size of a poppy-head ; in the center of a plaque on the shoulder a favus scutulum the size of a pinhead was visible.

Another case observed in a girl, æt. 13, was presented by Fox to the New York Dermatological Society, in whom forty patches of non-confluent lesions were visible, varying in size from a penny ; others of more or less extent, which showed slight elevations at the edge and were covered with small, thin scales of epidermis. A patch, oval in shape and of larger size, resembling ringworm, was situated on the left side, beneath the clavicle. The scalp was free. Some of the patches on the left breast showed scutula of pinhead size, with depressions in the center, and small spots of yellowish color were visible at the follicular openings.

A third case, by Schweninger and Buzzi, was that of a girl, æt. 12, in which a typical favus scutulum was situated on the right anterior half of the breast, and later there developed beneath the old scutulum a round, rosy-red spot. The head was not affected.

Havas reports a case of a child of six years who was affected with favus on the right half of the breast ; the lesions also showed the herpetic primary stage.

Jamieson reports the case of a child with one patch of favus the size of a shilling on one shoulder, the microscope confirming the diagnosis.

In the case of a boy 9 years of age, described by Debreuill and Sabrazès, there existed one small plaque on the right arm, above the elbow, the size of a two-franc piece.

Two cases in which the condition was situated upon the fore-arm : The first, described by Reynolds, in a child of 7 years, in which the patch was round, three-fourths of an inch in diameter and situated on the flexor surface of the fore-arm, slightly below the median line. In the center of the patch was

a favic crust one-fourth inch in diameter; three or four smaller cups, the size of the head of a pin, were scattered through the patch; otherwise it resembled *tinea circinata*, and the second, by Fink, who observed it in a boy of 9 years, and in addition to having two spots on the right fore-arm had one patch upon the back.

A unique case is reported by Jackson, occurring in a male of 19 years, in whom the eruption was limited to the left hand. It occupied the inner edge of the hand, extending slightly upon the dorsal surface, and also between the little and ring fingers, spreading nearly to the second joint of the third finger, being circular in shape. The patch around the edge showed well-defined vesicles; upon the back of the hand, in one place where the vesicles did not appear, there were four perfect favic crusts and one imperfect one; within the circle the patch was scaly and otherwise unaltered.

We quote two cases affecting the abdomen, one by Campbell, in a child two weeks old; the lesion was situated on the right side of the abdomen, immediately below the border of the last rib and to the inner side of its angle, and was one-half inch in diameter. The crust, when removed, left a denuded surface, presenting a cup-shaped depression. Nothing definite could be ascertained as to the source of contagion.

Another, by Smet, who noticed favus on the abdomen of a nurse who had been attending a child fifteen days old, which also had the disease—presumably since birth.

The two following cases are taken from Bulkley's report. One was noticed in a girl, æt. 11, who presented a patch on the left loin, just above the level of the sacrum. An oval patch of disease occupied an area of one square inch, on which were situated a few very characteristic and sharply defined favus cups; the rest of the area was occupied by a scaly, erythematous eruption, circling around the cups. No patch was seen elsewhere on the body or head. The other case was in a boy nine months of age, in whom a red, erythematous and scaly patch was visible on the left buttock; it was nearly circular, and about one and one-half inches in diameter; the margins were defined, with the center clearing up; scaling existed on the outer border, which was inflammatory in appearance; no cups were present.

We also add four cases affecting the genitalia and the surrounding parts. In the first, recorded by Pick, the lesions were present on the glans penis and sulcus coronarius. There were also erythematous spots of small size near the root of the penis

and the scrotum, and the internal surface of the thigh. These patches were marked with small elevations, arranged in a circle, and by vesicles; the lesions were crusted, the spots on the scrotum presenting a similar appearance. The second case, described by Bulkley, showed favus on the penis, scrotum and thigh; upon the penis and some parts of the scrotum well-defined, small favus crusts were visible. White, while commenting upon a paper by Sherwell, read before the American Dermatological Association, spoke of two cases in which he had seen isolated crusts upon the penis, and upon no other part of the body.

A case of favus in a girl, *æt.* 5, described by Bulkley, presented the following appearance: Small yellow cups were noticed on the right knee, depressed in the center, and typical; they were grouped together with an erythematous redness, showing moderate scaling between and around them; another patch, behind the left ear, consisted of a worm-eaten, dirty-looking mass, of a light yellow color in some portions, and in others much darker, about half an inch long by one-third of an inch wide, firmly adherent by means of some hairs passing through it; the characteristic cups were not seen.

Fox also reported a case affecting the knee, of which he procured a good photograph.

In his text-book of Diseases of the Skin, Anderson gives an illustration of a case of favus situated on the general surface, one patch being erythematous, and the other surrounded by vesicles, in the center of which the patch is covered with three or four favic crusts.

Contard records a case (in the service of Dujardin-Beaumetz) of cutaneous favus, presenting seven or eight patches over the body, of rather uncertain character. (The diagnosis, from the description of the author, seems uncertain.—EDITORS.)

In a paper read before the American Dermatological Association in 1892 Sherwell describes four cases of epidermic favus, occurring in the same family. The contagion could be traced to pet dogs which had contracted the disease from mice affected with favus. The two daughters of the family, aged respectively about 19 and 20, exhibited lesions on the arms, neck and breast. In the elder sister a patch existed on the upper and outer aspect of the arms, near the deltoid region, which were decidedly inflamed, and covered with sparse but characteristic scutula. The other patches, in the regions alluded to above, while showing a vegetable parasitic character, were



not so well-marked, nor were they in the younger sister. The mother and a young son were also found to be affected.

Devergie reported the case of a young man who had been affected with favus of the extremities since early childhood. This individual had been suffering from chronic inflammation of the intestines, was in a very emaciated condition, and was attacked with severe diarrhœa. The extremities were flaccid and quite thin, and their entire surface was covered with a favus growth from which the characteristic mouse odor emanated. During his stay in the hospital the patient contracted typhus fever; after recovering from the attack the favus had completely disappeared. Unfortunately, after he commenced to take nourishment and to gain strength the favus reappeared, the intestinal symptoms returned, the man gradually lost strength, and finally died. (The result of the autopsy, if one was made, is not given; and if there was none it is very unfortunate.—EDITORS.) This writer also quotes the case of a boy, 5 years of age, afflicted with favus, whose mother contracted the disease on her fingers from washing the child's head. The two sisters of this little boy also showed evidence of this affection on the upper lip and on the fingers. Kleinhans states that the scutula may occur on all parts of the face, as the cheeks, eyebrows, nose and external meatus of the ear. He refers to the case of a woman under treatment in the hospital for syphilis, in whom a beautiful favus scutulum developed on the tip of the nose. He thinks it probable that the individual contracted it from an adjoining patient suffering from that disease.

*(To be continued.)*

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ICHTHYOSIS CONGENITA (SO-CALLED HARLEQUIN FÆTUS).  
HISTORY OF A CASE STILL LIVING.<sup>1</sup>

BY

SAMUEL SHERWELL, M.D.,  
Brooklyn, N. Y.

THE cases reported of this curious congenital skin affection are so few in number, and so many of those, nearly all, in fact, having either been still-born or having lived only a few hours or days after birth; or, what is equally frequent, having been brought under the notice of the specialist, or particularly interested observer, some years afterward, when

<sup>1</sup> Read before the Eighteenth Annual Meeting of the American Dermatological Association May 30, 1894, Washington, D. C.

the life-history, etc., would be necessarily imperfect. I have deemed the following case, noted by myself from very shortly after the time of birth, worthy of a short report to this Association.

The infant, Annie S., was first seen by me on the 19th of January of the present year, through the courtesy of Dr. R. A. Black, of Brooklyn, the family physician. The child was born December 21, 1893, of American parents. The father, however, of German descent; both are quite healthy, in fact so far above the average, and aged 27 and 26 years respectively. The couple have two finely grown living children, girl of 7, boy of 4 years. The mother has had one still-birth at full time, and has lost one child of about a year old of an acute diarrhœic attack during a Summer.

The mother gives no history of shock, or of anything likely to have caused a maternal impression on the foetal life of the infant in question, but says, however, that she was more or less nervous from the quarrels of some of her relatives, which occurred during gestation.

As well as can be estimated, this child was born at term; nothing about the labor was in any degree noteworthy except that it was a breech presentation, and according to Dr. B., that during the necessary manipulation attending delivery, it felt more like a lizard than anything else. The absolute weight at birth was not ascertained, but was estimated at about two pounds. Placenta and membranes, the doctor states, were noted to be entirely normal. Mother convalesced rapidly. The doctor at first believed that the coating, which was estimated as from one-eighth to one-fourth inch thick almost all over body, was that of an unusually plentiful and abnormal vernix caseosa; but on closer examination found it so adherent and flaky, and the viability of the child so questionable, that instead of having it washed in the usual manner he ordered it to be plentifully lubricated with olive oil, and then wrapped in cotton; which, by the way, was and had been the only treatment adopted until I saw the child, a month later, and which treatment was continued by me for some considerable time after my first visit. The infant nursed very well, the dejections and urinary secretions, etc., fairly normal, and although it was then in such an apparently non-viable state, it had increased in size, etc., slowly but steadily up to the date of my first seeing it.

On sight I confirmed the doctor's diagnosis of ichthyosis. The apparent state was very pitiable, and my prognosis as to long

continuation of life was very unfavorable. It is difficult without prolixity to give an adequate idea of its condition at the time; it is almost sufficient to refer to the description and plate of Mr. J. Bland Sutton (reference later) and that of other writers on the subject.

The whole cutaneous envelop of the body and limbs from the plantar surfaces to the vertex was covered with soft horn-like scales varying in degree, but say from at least one-eighth to one-sixteenth of an inch in thickness, the scalp with a still thicker deposit of apparently a more sebaceous and irregular character. I should judge there that it was at least one-fourth of an inch in thickness. The natural flexures about trunk and limb were fissured to the derma propria, apparently here and there exposing the roughened true skin, and the whole appearance suggesting the fanciful name of harlequin fœtus, that has been given to this condition. One thing, however, was manifest: there was no especial deformity, or a special developmental lack, such as of cleft palate, or orbital, oral, or aural imperfections, or of their annexa; the mucous membranes apparently not affected, or but slightly. Ectropion moderate, fissures only of moderate degree around or at the angle and sides of mucous membrane openings, so that it seemed evident, in spite of the extremely small size of the infant, that before delivery term had been reached, or nearly so; another fact bearing on this was that the nails, though affected, corresponded in development with the rest of the body.

At the February meeting of the New York Dermatological Society I gave a clinical report of this case, and extended an invitation to the members present to come and see it. I was so favored by only one of my colleagues, Dr. A. R. Robinson, a week or so later. But at the meeting of the same Society April 24, 1894, I was fortunate enough to be able to present the case; about fifteen members were present, and I believe I can say that the diagnosis was confirmed by all.

I have on the average from my first visit up to the present time, a day or two since, made a visit every ten or twelve days, expecting at each of the first two or three of them to hear that the child was dead, or at the point of death; but to my surprise it still lives, and is even now doing well. Its general condition, while improved, owing to the assiduous care and devotion of the mother, is still a pitiable one, though the striking and repulsive objective symptoms are in large part removed. I cannot even now believe it will grow up.

Its present condition and treatment is as follows: The bathing with oil alone was continued for about the first two months, during which time olive and soft vaseline were used in great excess all over body and head, so that eventually maceration with them and gentle friction had sufficed to remove what might be called the outer exuvial skin, and to permit of getting down to the more recently formed epidermis. That of the back and head was most resistant to this treatment. At this time it had an almost ridiculous resemblance to a "*Harlequin avec une tête de Pierrot*." Shortly after, however, it evidently becoming a little stronger, sponge and other baths with alkaline water (generally borate of soda) were given daily, inunctions following. Sometimes these were of olive oil, sometimes vaseline; later on ungt. aq. rosæ was used a good deal; for a time I supplied this latter, but the mother, unable to buy this herself, although relatively poor, was too independent to ask for continued charity, and decided upon using mutton fat, somewhat softened, which she fries out fresh. As the child seems to be doing as well with this as anything, I have let her continue its use, adding a little ol. amygdal. dulc. to make it blander. My reason for not using the raw linseed oil, which is a favorite application of mine in somewhat similar affections, is that it oxydizes too rapidly, and would have been taken up by the cotton and formed a varnish and not an unguent. A patient should be naked and only lightly covered who would use this latter to advantage, in order that plentiful and constant, or at least frequent, reapplication be permitted.

Owing to the admirable cleanliness observed by the mother, and the frequent though relatively slight inunctions compared with those of former date, the appearance of the child's skin is much less striking than it was; even the casual observer would, however, notice the relatively thin general scalings, and that the skin seems thinner underneath this, but parchment-like, roughened at the back, etc., the palms and soles have a peculiarly bright and glistening look, but dry and pergamentous feeling. The infant lies all the time with the eyes closed, by preference, it would appear; it can open them readily, but I think the pain of the small, though constant fissures of the canthi causes this. The same may be said of the mouth, which is stiffened around what should be the vermilion border of lips. There is now no positive ectropion, as at first. If neglected as to bathing, etc., for a day, as I have once or twice required, there forms in the twenty-four hours an extensive aggregation



of scales over the whole surface. The infant is very sensitive to cold, and the pruritus must be very great, as hands and feet are in almost constant motion from evident desire to scratch. The mother, without my order, but now with my permission, has to give it soothing syrup two or three times a day or night, for it and herself to obtain needed rest. It now weighs a scant seven and a half pounds, and the bowels and other viscera act almost normally, the only internal medicine that has been given at any time having been a few grains of hydrag. c. creta in fractional doses.

An examination by a competent histologist of a portion or portions of excised skin would have been doubtless desirable and interesting; but I may say that I have not as yet dared to ask the parent's consent. The mother to whom this child, in my belief, owes its continued existence would rather part with her own. In case of its decease (as she is a very reasonable human being, however,) I think I could, and will try to obtain, some sections for examination. I may add in regard to the mother that she is quite a rosy, rotund, good-natured sort of a woman, the very type, to all appearance, of a good wet nurse. I think the above statement contains all the essential features of the case, and would in conclusion say that in my belief this congenital condition is only alleviable, not curable. As to the literature upon the subject, I have tried to arrange the names of those who have written on this condition and whose articles I have read as nearly as I can chronologically. I will spare you any long dissertation on their observations or conclusions; they can be looked up by those interested.

Richter of Leipzig, 1792, is the first recorded observer I can find, and he only as mentioned by Lebert of Breslau, 1864, who under the title of "*Keratoma Diffusum*" published an article in which he mentions ten cases, of which Richter's is the earliest. Lebert particularly dwells upon the occurrence of this congenital condition in the lower animals, calves, etc.

Fröbelius, *Petersburg, Med. Zeitung*, 1865.

Sir Jas. Simpson, *Edinburg Med. Journal*, 1865.

Jonathan Hutchinson, *Lectures on Clinical Surgery*, 1879, and again in *Archives of Surgery*, 1891.

Kyber, *Med. Jahrbücher*. Wien, 1880. On case observed in Odessa, 1872.

Wheelock, *Illust. Med. and Surg. Jour.* New York, 1884.

Behrend, *Berliner Klin. Wochen Schrift*, 1885, No. 6.

J. Bland Sutton, *Medico. Chirurg. Transactions*, 1885.

Caspary. *Vierteljahreschft. f. Derm. u. Syph.* 1886.

Geo. T. Elliott, *Jour. Cutan. and Genito.-Urin. Dis.*, January, 1891, and others.

All the prominent dermatological authors in their treatises make mention (sometimes a bare one) of the occurrence of this congenital condition. Among these Kaposi may be cited as defending the dictum of the elder Hebra that all viable children, at least, born in this condition are affected, not with true ichthyosis, but ichthyosis sebacea. I do not think he is right in this, the able articles of Caspary and Elliott and others would seem to disprove this assertion; and in this connection would also like to refer you to an interesting article in Pick's *Archiv. f. Dermatologie u. Syphilis* for this year, Band XXVII. Heft I. by S. Giovannini, entitled "*Ueber einen Fall von Ichthyosis mit hypertrophie der Schweisadrüsen.*"

33 Schermerhorn Street, Brooklyn.

## THE IDEAL TREATMENT OF ACUTE GONORRHŒA. IS IT JUSTIFIABLE?

BY

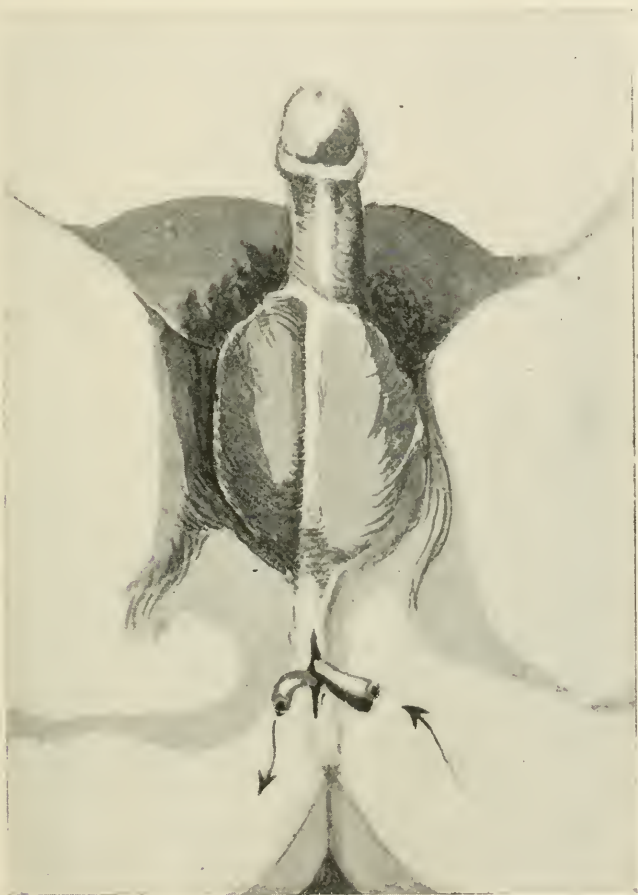
BURNSIDE FOSTER, M.D.,

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Surgeon to the Skin and Venereal Department of the St. Paul City and County Hospital,  
Dermatologist to St. Luke's Hospital, Dermatologist to St. Joseph's Hospital, Visiting  
Physician to the St. Paul Free Dispensary, etc.

IN view of the serious and far-reaching results of acute gonorrhœa and its complications, I believe that, if we can give our patients a reasonable hope of being cured in a comparatively short time, and of escaping the ordinary complications, we are justified in putting them to bed and subjecting them to a somewhat radical method of treatment. The great objection to early local treatment as at present employed lies in the danger of washing the infection backward, and thus inviting infection of the posterior urethra and its appendages. The method I propose obviates this objection in that we can attack the urethra from the rear, and always wash from behind forward; the method also has the advantage of placing the inflamed portion of the urethra pretty well under our control. To be brief, I would suggest that as soon as may be after we have established the diagnosis of a *first* gonorrhœa, the patient

should be etherized, properly prepared ; a buttonhole opening made in the perineum, and drainage of the bladder established. (See cut.) Through a properly contrived apparatus the anterior urethra could then be thoroughly flushed with any antiseptic or cleansing fluid and treated on surgical principles. The details of



local treatment would vary with the fancy of the operator. The feasibility of packing and distending the anterior urethra with iodoform gauze, suggests itself to me ; but anyone of a great number of methods would, doubtless, be efficacious. I have never had the opportunity to adopt this method of treatment, which, should it be deemed justifiable, would naturally have but

a limited field. Those who are so circumstanced that the very fact of their being ill at all must be carefully concealed would naturally not submit to it, and many of those who would be willing to go to bed for a time would shrink from any cutting operation for the cure of what they consider a comparatively trivial affection. It would be well if the youth of our land could be educated to the fearful dangers of a neglected gonorrhœa, both to themselves and to their wives, and I believe that if this method were adopted it would have the result of very greatly elevating the standard of sexual morality. For, if gonorrhœa were generally known to be a dangerous disease, and one demanding such radical means for its cure, many a young man would hesitate before he ran the risk of requiring it. I make this suggestion thus briefly in the hope that some of those whose clinical facilities are more abundant than my own may be inclined to make trial of this method and report their results.

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A PLEA FOR RECTAL EXAMINATION IN THE DIAGNOSIS OF  
OBSCURE DISEASE OF THE SEXUAL SYSTEM.

BY

W. H. BRINLEY, M.D.,

Minneapolis, Minn.

THE most careful and fastidious persons are frequently guilty of the grossest neglect of the lower orifice of the alimentary canal. Particular, to an extreme degree, in the care of the mouth, throat and general person, daily washing and brushing the dental system, securing immediate professional service to the slightest decay or trivial inflammatory action in this region, they will continue for years constipated or obstinately neglect rectal trouble of which they are aware. Even more than this, they will at times deny its existence when questioned by the medical attendant.

And all through ignorance or a sense of false modesty. The rectum is a Pariah in polite society, under no circumstances to be even mentioned except as the synonym of filth or degradation. In spite of this neglect, it goes on silently fulfilling its mission and submitting to a host of abuses as best it can, returning good for evil.

Were but the truth of the importance which this portion of human anatomy exerts in its proper or improper function over



the well-being of the entire animal economy, shrines would be erected which are not dreamed of to-day, and worship in the temple of Cloacina would become a pleasure never to be neglected, instead of an irksome duty as at present in most cases.

And even in the professional mind this extremity of the digestive canal is not treated with that regard to which it is entitled, if we may judge by what is written, and the many instances of neglected disease in this region which have been overlooked through a lack of appreciation of their existence, or the treatment of remote reflex results of such local irritation, instead of addressing the pathological spot itself that is the direct cause of these abnormal effects.

How many physicians are ignorant of the fact that dilatation of the sphincter muscles in the rectum exerts a profound influence over both respiratory and circulatory systems? And yet this simple fact can be easily demonstrated by stretching the internal sphincter either by the fingers or a speculum, and observing the catch in the breath of the subject operated on, or, still further, noting the sudden flushing of the face. Let the doubting Thomas place his fingers on the spot and be convinced! Its knowledge may enable him to save a life endangered by the heart-failure which sometimes accompanies anæsthesia, or help him to put the breath of life into that new-born child, to which all other efforts have proved futile. Or, again, he may find this means of incalculable service in any of the many forms of narcosis that are constantly to be met with.

But the main object of the writer is to direct attention to the rectum as the seat of trouble which directly concerns the sexual system of man. It has been his lot to meet patients who had been troubled in this way for years, trying medical adviser after medical adviser, in whose ears he has poured his woes, always being assured of cure, but remaining the same. Submitting to enlargement of the meatus and internal urethrotomy for the cure of suspected stricture, enduring the distress of caustic applications to the prostatic channel for the cure of fancied follicular inflammation, aspirated for chimerical hydrocele, irrigated for imagined sub-acute or chronic cystitis, and through it all not a thought given to the rectum. Finally, when examined and informed that trouble existed there, exclaiming in amazement: "Why, doctor, I have spent thousands of dollars and consulted dozens of physicians, and not one of them has ever looked there." It seems incredible, but it is a fact, and we hold that no one is justified in neglecting a careful examin-

ation of the rectum in any case of genito-urinary disease as a means of diagnosis.

It is unnecessary to consider here the forms of urethral trouble which are so apparent to the experienced eye as to preclude the possibility of mistake, as, for example, an acute urethritis. The history, if carefully considered, will at once demonstrate its character as a benign or specific discharge; or if doubt exists, the microscope is called to aid.

Equally simple is the way in the matter of stricture, a traumatic occlusion being easily distinguished from one caused by repeated pathological inflammation of the membrane. Careful manual inquiry into the condition of the prostatic and membranous urethra will determine the exact condition of these parts if the lesion is acute or well marked; but the investigation at times must be extremely deliberate and enforced by a competent knowledge of the varying conditions which are here to be met. The reflex symptoms of a vesical calculus must not be confounded with the localized sensation of a follicular irritation any more than the degeneration of sexual activity, or its opposite condition of unnatural sexual stimulation due to the presence of an elastic stricture, be tangled in the mind by the same phenomena, caused by irritation of pathological changes in the rectum. It is in just these cases that the importance of studious investigation of the surrounding anatomical regions is never to be lost sight of, which is to decide the result of the diagnosis, and which will determine the ultimatum of the treatment, namely, the cure of the patient. If an error is committed he is left in the same condition and the mistake rebounds to the detriment of the profession.

In an examination of the rectum for possible causes of perverted conditions of the sexual system the first requisite is a good speculum. A bi-valve answers the purpose admirably; it should be capable of considerable distension and afford a clear and unobstructed view of the rectal walls. The Pratt instrument answers these requirements perfectly.

The first condition naturally looked for is hæmorrhoidal tumors. If of large size they are immediately recognized, and the necessity for removal needs no advocate. But if, as in many cases, they do not exist in this form, but patches of discoloration are seen, it is well to relax the pressure on the handles of the speculum so as to permit the blades to approximate; this being done, it will frequently be noticed that the spots of discoloration reveal the presence of numbers of small

pile tumors beneath the mucous membrane, which have been aptly likened to a cluster of grapes. It is equally important to sexual health that these should be removed, as in the case of their larger brethren before mentioned.

And right here it would be proper to assert that the rational method of removing all hæmorrhoids is by excision. The use of the ligature and clamp is as unscientific as would be their application in the amputation of a finger or toe. With the improved specula and forceps of this age, no one need use any other method, and if necessary the entire mucous surface of the last inch and a half of the rectum may be bodily dissected away.

Another condition found in this region is ulceration. The character of this is usually indolent and frequently exists for years unsuspected. Situated between the internal and external sphincters, the opposing muscular forces prevent physiological rest, and as a result this condition continues indefinitely unless counteracted by remedial measures, working, in many cases, incalculable mischief to the sexual equilibrium. Ulceration of the mucous membrane in this situation becomes a prolific source of reflex disturbance to the sexual organism, and these reflex conditions are obstinately persistent until the irritating cause is removed. It is worse than useless to palliate by local treatment of the urethra in these cases. The sooner the true site of disease is recognized the better. Excision of the ulcerated spot is undoubtedly the most radical measure and more promptly efficacious than the application of caustics, although healthy reaction may be produced by this latter method, or even simple dilatation.

When found in this situation, papillary growths, fissures, fistulæ, or other manifestation of degeneration should be conscientiously treated, while another condition not infrequently found in this region should never be neglected. This condition is atrophy, and is commonly the cause of as much mischief in this relation as the opposite extreme of hypertrophy.

The importance of the great sympathetic system should not be overlooked, and it is largely through this medium that the disturbances occur.

If the thought here given were closely followed it would be the means of bringing great relief to many cases which have been erroneously abandoned under the mistaken theory that the trouble was purely psychical. It is reasonable to suppose

that any suggestion would be welcomed which held out the prospect of a radical diminution in number of the army of unfortunates known to the profession as sexual hypochondriacs.

251 Nicollet Avenue.

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## Society Transactions.

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### THE AMERICAN DERMATOLOGICAL ASSOCIATION.

EIGHTEENTH ANNUAL MEETING. HELD IN WASHINGTON, D. C.,  
MAY 29, 30 AND 31, 1894.

DR. GEORGE T. JACKSON, *Vice-President, in the Chair.*

**Thyroid Feeding in Diseases of the Skin.**<sup>1</sup>—By DR. GEORGE T. JACKSON of New York.

DR. FOX said he regarded the conclusions judicious, and in looking over the literature he had been convinced that if the cases reported had been put to bed and given any intelligent treatment, or no special treatment at all, probably as brilliant results would have been obtained. Before judging of the effects of a new remedy we should have a pretty definite idea of what would be the natural course of the disease.

DR. HYDE said he had ventured somewhat on this field, having tried thyroid feeding in psoriatic cases only. He had begun with large doses, and as required had reduced the quantity. He presented a record of ten cases of psoriasis, some severe and some moderate. The average length of time they had suffered from the disease was thirteen years. Two exhibited such unpleasant symptoms from the remedy that the speaker was convinced of its danger, and in the others he saw no benefit accruing to justify him in any further use of the remedy.

DR. HARTZELL has given the remedy a trial in eczema, two or three cases of psoriasis and one of ichthyosis, without obtaining any effect whatever. He would not draw definite conclusions from so few cases, but thinks that where favorable results are obtained they must be due to some other cause.

DR. STELWAGON had found no good results in ichthyosis, dermatitis exfoliativa or pityriasis rubra pilaris. Five grains of dessicated thyroid was given three times a day at first and increased to twenty-grain doses. Treatment has extended over three or four weeks, and the patients were glad to give it up. In one case of psoriasis, oedema of the feet and legs resulted.

DR. CORLETT said that from recent conversation with English experimenters he found the tendency was to give up thyroid, except possibly in lupus vulgaris, where it seemed to give some promise.

**The Rare Forms of Alopecia.**—By DR. GEORGE H. FOX, of New York, the writer limiting his remarks, however, to his personal observations in a number of cases of folliculitis decalvans.

Photographs on glass were passed for inspection, which the speaker thought would prove more instructive than anything he could say—one,

<sup>1</sup> Will be published.



illustrating an advanced stage, showed a large depressed pigmented cicatricial patch. He believed the disease begins by the formation of one or more tender elevated hyperæmic patches, usually small and circular or oval in shape. Tenderness remains at the margin. The essential condition seems to be an inflammatory plugging up of the follicle. The hairs loosen as in alopecia areata, and twenty or thirty can be pulled out in a bunch without pain. The root sheaths are often attached. A large number of small patches may coalesce. The crown of the head seems mainly affected. In the early stage it differs from alopecia areata only in the redness of the patch, and in the later stages in the peculiar sinking or atrophy.

The term keratosis might be applied to the plugging up of the follicles in the vicinity of the patches, but whether this keratosis precedes the inflammatory condition or whether the disease is essentially inflammatory in its origin is still a question to be decided. Treatment has been very unsatisfactory and no plan can be recommended as positively curative; shaving the patch and the application of 10 per cent. salicylic ointment is perhaps the best.

DR. ZEISLER said he had never seen in Vienna an affection designated by this term, but had seen at least half a dozen cases which he had put down as folliculitis decalvans, and is now convinced after seeing the excellent photographs that this diagnosis was correct. He had also seen a case in which this diagnosis had been made where the patient was really suffering from favus, and he thought that after the scales of favus had been removed it might closely resemble this condition.

DR. HYDE said he believed that some of these scar-leaving alopecias may be tuberculosis of the scalp. Occasionally, too, odd varieties of lupus erythematosus spread over the scalp, leaving peculiar scars. We do not expect inflammatory diseases of the skin to leave a scar. He thought that one day we shall have a pathological basis for studying these conditions and not group them all under the one title.

DR. SHERWELL thought a great many different etiological factors were present in the cases described. Quinquand was one of the earliest writers on the subject and he considered the condition syphilitic, though an unusual manifestation. He employed white precipitate ointment, which he considered almost a specific remedy. In some instances there may well be a discoid erythematous lupus present.

DR. FOX said in closing that he had omitted to state that the hairs are generally broken off. He had not meant to claim that all these rare forms of alopecia should be associated under the term folliculitis decalvans, although a few years ago they were generally classed under alopecia areata. No doubt distinct forms will be described, but most of the cases which have fallen under the speaker's observation could be classed under the term folliculitis decalvans. Some of them may be allied to erythematous lupus, which on the scalp leaves a strong resemblance to folliculitis decalvans, except that the projecting hairs from the horny cones are never met with. He cannot associate the condition in any way with syphilis.

**A Case of Favus of the Head and Body**<sup>1</sup> was the title of the next paper, read by DR. CASTRELL, of Philadelphia.

DR. JACKSON said that during the past five years he had seen many

<sup>1</sup> See Page 375.

cases of favus in his hospital service, but none of the general integument. He could recall but one instance upon non-hairy parts. This was upon the hand and contracted from mice. In this case the vesicular ring described by Köbner and others was well marked.

DR. ZEISLER referred to an extraordinary case of primary localization of favus in the nails of the toes.

He said that while we can not well explain how the favus germs can live and thrive in mucous membranes not exposed to the air, still we must accept the fact since the microscope settled the question in Kaposi's case.

DR. CORLETT had seen extension over the face in one case.

DR. WIGGLESWORTH said favus seemed to flourish by predilection upon the hairy scalp, and the difficulty of inoculating it upon the skin elsewhere is thus explained.

He and Dr. White had tried to induce the disease in a man by every possible means. Only when using the crust in the form of a powder, and pricking it into the hair follicles, did the experiment succeed and favus cups follow. There seems to be special difficulty in making the spores attach themselves in other places.

DR. HYDE said his experience had been that body cases are rare. Last year he had observed a child, a Newfoundland dog and a woman living together in a cellar, all affected with favus.

Subsequently an elder brother of the child suffering from the same disease was brought to the clinic. He was 21 years of age, and stated that he had had the disease all his life, and still there had been no extension beyond the scalp.

DR. STELWAGON had treated the case in question for some time. It was the first instance of generalized eruption he had ever observed, though he had seen it limited to one or two patches upon so-called non-hairy parts. He so far agreed with Dr. Hyde as to the rebelliousness of favus of the scalp that he could not state that he had ever permanently cured a case.

DR. HYDE had found it of advantage to change the treatment frequently, applying, for example, bichloride one day and sulphuric acid the next.

DR. WHITE said he had seen favus upon the glans penis. He regarded the affection curable in time. Among the Russian immigrants he had often seen cases of cured favus, or at least the disease had died out. He could claim one positive cure, in a patient who had been under observation for fifteen years. Favus upon the general surface is very readily cured.

DR. HARTZELL referred to a glans penis case reported where the observer had discovered the presence of a minute hair, showing it to be no exception to the rule that hairy parts are alone affected.

DR. ALLEN had seen many of such cured cases as were referred to by Dr. White, especially among so-called Polish Jews. At times a fringe of hair only would be left surrounding the bald scalp. In a number of cases, however, what looked like the results of favus he had thought was in reality the baldness produced by such follicular affections as Dr. Fox had discussed in his paper.

**Cold as an Etiological Factor in Diseases of the Skin.**<sup>1</sup>—Read by DR. W. T. CORLETT, of Cleveland.

<sup>1</sup> Will be published.

DR. SHERWELL spoke of the resemblance some of the cases bore to the conditions described by Mibelli, Brooke, and others in which the action of cold has been advanced as a factor.

DR. HYDE said the influence of cold atmospheres upon cutaneous disorders is most apparent at the first decided changes of Autumn. When the hands alone are affected other factors besides cold are responsible. There is a local infection of the mixed type which Walter Smith recognizes under the term *eczema marginatum*.

DR. CORLETT'S cases seem to show the right hand to be that mostly affected. This is significant, since occupation influences these cases to a marked extent.

Care must be exercised in eliminating other sources of disease before attributing the condition to cold alone.

DR. WHITE said if he were asked to make a diagnosis from the illustrations presented he would call the condition *eczema*, qualifying the term. It may be aggravated by cold. Where cold is the most important etiologic factor the distribution is more generalized, and there is a greater variety of lesions, chiefly *eczematous*.

DR. CORLETT said in closing that so far as he had been able to ascertain the right hand was not more frequently affected than the left, and *vice versa* in left-handed people.

He had not desired to add to the list of diseases, but to record a clinical fact, which, if confirmed, should have some distinctive name applied to it.

*(To be continued.)*

## AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

EIGHTH ANNUAL MEETING, HELD AT WASHINGTON, D. C., MAY 29, 30,  
31 AND JUNE 1, 1894.

DR. GEORGE CHISMORE, *President, in the Chair.*

*(Concluded from page 358.)*

## GENERAL SESSION OF CONGRESS.

UNDER THE DIRECTION OF

THE AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

**Nephritis in Its Surgical Aspects.**—DR. EDWARD L. KEYES, of New York, read a paper on this subject, in which he confined his remarks principally to suppurative pyelonephritis, commonly known as "the surgical kidney." His paper was divided into three parts—introductory, practical and bacteriological—and he detailed a number of observations conducted by Dr. Dunham, of the Bellevue Hospital Medical College, under his direction, with the object of determining the destructive or inhibitive power of various antiseptic remedies. This investigation showed that nitrate of silver was by far the most reliable agent we possess in counteracting the effects of local contamination. Salicylic acid was shown to be a very reliable anti-

septic. He also found that boracic acid had but little or no value. His conclusions, briefly summarized, were as follows:

1. Healthy urine is sterile.
2. Purulent urine is always microbic.
3. Microbic infection takes place from within the body by a number of methods in the course of disease; it is often brought about by instrumental manœuvres on the part of the surgeon.
4. A healthy organism and vigorous bladder may cope successfully with microbic invasion and rid itself spontaneously, or with a little aid, of all damage arising therefrom—showing little or even no inflammatory response.
5. A suitable condition of the patient's soil is essential to the propagation and perpetuation of inflammatory phenomena upon the urinary tract—after microbic invasion.
6. This condition, intensified by traumatism and physical weakness, notably of the degenerative variety, is most intense when there is vesical distention with atony, and when the ureters are dilated and the kidneys involved in the changes incident to tension below—namely, atrophy and sclerosis above, with or without surface catarrh.
7. Under these circumstances surgical pyelonephritis is most likely to declare itself as a result of microbic infection from below (occasionally from above)—in the course of suppurative disease or after operative interference.
8. Asepsis, antisepsis and sterilization of urine are ends to be aimed at in genito-urinary surgery; but, like all other greatest goods, not yet attained in perfection. Much, however, can be done by local means in a prophylactic and curative way, little by internal medication, and possibly as much or more than by any other means by flushing the urinary passages with natural mineral waters.

**The Bacteriology of Pyelonephritis.**—By DR. GEORGE M. STERNBERG, Surgeon-General, U. S. A.

The author stated that in considering the etiology of nephritis a broad distinction must be made between those forms known under the general name of Bright's disease and pyelonephritis, or the so-called surgical kidney. In the first-mentioned forms, which may be denominated hæmatogenous, the primary cause of the renal inflammation is, as a rule and perhaps always, some toxic substance in the blood which acts as an irritant to some portion of the renal parenchyma. And when micro-organisms are found in the urine in cases of this kind, or in sections of the kidney removed post-mortem, their presence is probably to be regarded either as accidental or as secondary to the changes in the kidney rather than a cause of these changes. It is not at all unusual to find colonies of micrococci or of bacilli in the necrotic foci found in certain forms of nephritis, but the inference that the inflammatory process and resulting necrosis were due to these bacteria is not justified either by the microscopic appearances of the sections or by experimental investigations. On the other hand, in ascending nephritis or pyelonephritis, which is very commonly secondary to a cystitis of long standing, there is a good reason to believe that the inflammatory changes and pus formation depend principally upon the presence of certain bacteria which are found in the urine of such patients during life and in



the diseased kidney removed by surgical operation or post-mortem. And recent researches show that the bacillus coli communis, which is constantly present in the intestine of healthy individuals, is found more frequently than any other micro-organism in the so-called "surgical kidney." This bacillus is now known to be the usual cause of peritonitis. It has been obtained, in pure culture, from a number of cases (8) of abscess of the liver, from urinary abscesses (6), and from the pleural cavity in certain cases of pleurisy (9).

After a careful review of the literature and bacteriology of this subject Dr. Sternberg said he thought we are justified in concluding that cystitis and ascending pyelonephritis are usually caused by micro-organisms introduced through the urethra into a bladder which is rendered susceptible to infection by mechanical violence or chemical irritation. And that the most frequent cause of such local infection is the bacillus coli communis, which is constantly present in the intestine and upon the external surface in the vicinity of the anus, from which it may easily be transported to the interior of the bladder by catheters, etc., used by the patients themselves or by their medical attendants. According to Bouchard, it has been shown that this bacillus is sometimes found under the prepuce and about the vulva of healthy persons, and this is what we should expect from their proximity to surfaces which are constantly soiled with discharges containing it. But there is no evidence that the bladder is reached by the direct invasion of this or other bacteria without mechanical assistance. The researches of Lustgarten and of Mannaberg and of Krogius show that the bacillus coli communis is not found in the normal urethra.

DR. CHISMORE said that the conclusions drawn from his own experience agreed very closely with those of Dr. Keyes, yet in some points he differed. Instead of stone in the bladder being so frequently the cause of nephritis, it has seemed to him that, under certain circumstances, the reverse is the case. The presence of a stone in the bladder, particularly if it is of small size, which gradually becomes larger, seems to render the bladder more tolerant to instrumentation. In the young subject the bladder is very resentful, and the introduction of an instrument in such patients is apt to be followed by renal mischief, especially of an acute inflammatory character. In cases of polyuria, with urine of low specific gravity, the dangers of instrumentation are very pronounced. The method of attacking microbes by injections into the bladder has always seemed to him to be confessedly faulty; by this procedure many of the micro-organisms are left untouched, and there is always more or less danger from the over-distention and shock. It is not always easy to diagnose tubercular affections of the bladder or kidney in the earlier stages, and this fact should make us still more conservative, because the view is now generally accepted that in tubercular cases instrumentation is likely to produce serious injury without any corresponding benefit. Strong injections of bi-chloride solutions should also be avoided; even the weaker solutions have a certain toxic effect and may be the means of inflicting traumatism.

DR. WATSON said he would confine himself simply to one point in the treatment of pyelonephritis, and that is long-continued or permanent drainage of the bladder. A number of surgeons, among them Sir Reginald Harrison, have called our attention to the importance of this procedure in the treatment of surgical kidney, and urged its more frequent employment on

the profession. In six cases of the disease coming under his observation the patients were greatly benefited by long-continued drainage of the bladder. All of these patients were over fifty years of age; they suffered from hypertrophy of the prostate and presented symptoms of pyelonephritis. In four of the cases the disease was in the acute stage and in two in the chronic stage. In four of them the disease had supervened rather suddenly after the beginning of catheter life, and in the remaining two it occurred without apparent exciting cause. In two of the cases the bladder was drained by means of a catheter passed from the meatus, and in four of them by means of a soft rubber drain introduced through a perineal opening. In all of the cases polyuria was a prominent symptom, and the first sign of improvement was a diminution in the quantity of urine and an increase in its specific gravity. The speaker said he did not wish to be understood as claiming too much for long-continued drainage in the treatment of these cases. In certain instances nephrotomy has its place, and possibly nephrectomy. Still, long continued drainage of the bladder is a very important measure, and the cases in which it is especially applicable are old prostatitis, in whom the disease is already well marked or appears to be rapidly developing. As regards the method of employing permanent drainage in these cases: The introduction of a catheter through the meatus is the simplest and least dangerous method, although it is apt to set up a urethritis. The catheter can be tied in, no matter what the condition of the patient may be. The best method, probably, is to insert the tube through a perineal opening. In one of his cases the patient wore a perineal tube for three years with entire comfort.

DR. KEYES, in closing the discussion, said that in his paper he had emphasized the statement that the bladder is the guardian of the ureters. He is familiar with the procedure spoken of by Dr. Watson and has practiced it. In cases where the bladder cannot be spontaneously emptied a certain amount of good is obtained by the frequent use of the catheter—perhaps once in six hours—and still more by drainage either through the urethra or perineum. There is no doubt of the fact that surgical kidney may occasionally occur spontaneously. It is an ascending nephritis, rarely a descending nephritis.

**Mixed Malignant Growth of the Testis.**<sup>1</sup>—DR. R. W. TAYLOR read a paper on this subject and exhibited a colored drawing showing the appearance of the growth.

DR. BANGS referred to the difficulties that often surround the diagnosis of tumors of the testes and scrotum, and detailed the history of a case of epithelioma of the scrotum coming under his observation.

DR. BRYSON said that in tumors involving the testes or the cord the growths are seldom typical; they are apt to be composed of mixed elements, and in the treatment of these cases radical measures are usually indicated. A practical point of importance is to make the differential diagnosis between syphilis and tuberculosis. In malignant or tuberculous growths the administration of the iodides in any considerable amount is apt to produce bleeding.

DR. BANGS said he is accustomed to remove the glands in the groin in these cases if they seem to be infected. This is in accordance with the gen-

<sup>1</sup> See page 321.

eral rules of surgery, although he has no fixed rule regarding it. In one case of carcinoma of the testis coming under his observation the inguinal glands were not removed, and two years later there was a recurrence of the disease in the kidney on the affected side; the inguinal glands were not involved.

DR. BRYSON said that in one case of sarcoma of the testis coming under his observation there was a recurrence of the disease in the intra-abdominal glands. The inguinal glands were not involved.

DR. KEYES said he has seen a number of these mixed growths of the testis, and in each instance the recurrence of the disease was in the retro-peritoneal glands—never in the inguinal glands. If the disease has escaped its natural fibrous boundaries, and the tissues surrounding the testes or cord are implicated, there is no reason why the inguinal glands should not become affected.

DR. BELL said he agreed with Dr. Bryson that tumors of the testis, in almost every instance, sooner or later show signs of malignancy. In one case of sarcoma of the testis coming under his observation a recurrence of the disease took place in the pelvis. On account of the anatomical connections the inguinal glands are only likely to be affected secondarily in these cases.

DR. TAYLOR then closed the discussion.

**Two Cases of Syphilis Having a Bearing on the Question of the Period During which the Disease is Communicable.**<sup>1</sup>—By DR. JAMES BELL, of Montreal.

DR. TAYLOR said that while the first case reported by Dr. Bell is rather puzzling it is possible that there was some extra-genital source of infection. He has the records of a number of cases in which the husband was suspected of infecting the wife, and in which it was afterward found that the infection came from some other member of the family. In one case coming under his observation a servant was the source of infection; in another a child. Still, the case reported may be one of those unusual ones in which the infectious period of the disease persists. The blood is the least potent agent in the infection of syphilis. The suspicion of a lover in these cases should also be borne in mind. The second case reported Dr. Taylor said he regarded simply as fortuitous. A number of such instances have come under his observation.

DR. JUDKINS referred to a case coming under his observation in which a man married four months after the appearance of the initial lesion. Two months later the patient's wife showed unmistakable symptoms of syphilis, and since then she has aborted five times.

DR. BELL said that in the first case reported in his paper he had no reason to doubt the truthfulness of the woman's story. He did not think there was a lover in the case. He was inclined to regard it as a case in which there was a persistence of the secondary stage, with rupture of the genital mucous membrane during coitus and intercommunication of the blood.

DR. KEYES said that in the case reported the initial lesion appeared twenty-eight months previous to the date of the man's marriage. Clearly, he was not yet out of the high-road of possible infection, no matter what

<sup>1</sup> Will be published.

his treatment was. Such a thing is entirely possible and not very exceptional. The source of infection may have been a small mucous patch on the penis which escaped his attention.

DR. BANGS said that some time ago, after a careful study of the literature on this subject, he arrived at the conclusion that it is not safe to permit marriage in these cases until after three years have elapsed.

The following officers were elected for the ensuing year :

*President*—Dr. L. Bolton Bangs, of New York.

*Vice-President*—Dr. Francis S. Watson, of Boston.

*Secretary and Treasurer*—Dr. W. K. Otis, of New York.

*Member of Council-at-Large*—Dr. J. A. Fordyce, of New York.

It was decided to hold the next meeting of the Association at the Clifton House, Niagara Falls, during the last week in May, 1895.

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### THE NEW YORK DERMATOLOGICAL SOCIETY.

233D REGULAR MEETING. HELD ON TUESDAY EVENING, MARCH 27, 1894.

DR. ALLEN, *President, in the Chair.*

**A Case of Erythema Annulare.**—Presented by DR. S. SHERWELL.

The patient was a male, aged 52. The lesion originally appeared in June, 1891, as an inflamed, pink, itching spot one-quarter of an inch in diameter, about the center of the palm of the right hand. This enlarged in all directions, and in about thirty-six hours it developed into a symmetrical ring, with a center of natural colored skin. This circle of pinkish hue continued to enlarge and in about nine or ten days it reached the borders of the palm, when it disappeared. During its progress it was very irritable when pressed or scratched. A few days after the disappearance of the first lesion a second similar one appeared, and the same phenomena occurred. This was repeated three or four times, when a similiar lesion appeared on the palm of the left hand, and later on another on the right hand, near the base of the fore-finger. Soon afterward, a single spot appeared on the sole of the left foot, which disappeared and was replaced by another.

At the present time the patient presented a single lesion on the palm of the right hand, which was gradually extending peripherally. The patient's personal history was negative. He was in good health. He was now engaged in light business, but at one time handled considerable varnish, which contains linseed oil and spirits of turpentine.

DR. SHERWELL, in reply to a question, stated that on one occasion the man had the lesions on both palms at the same time. The case was considered by most of the members present as a case of erythema multiforme or circinatum (erythema iris), with some unusual features in regard to localization and to recurrence, particularly by DRs. FOX, BRONSON, FORDYCE, LUSTGARTEN and ALLEN.

DR. FORDYCE referred to a case of papular erythema now under his observation in which the lesions were confined to the backs of the hands and fore-arms, and had persisted for almost a month. A short time ago he



had seen papular erythema develop simultaneously in two Irish girls, sisters, who had only been in this country for a short time; in both those cases the eruption was attended with the formation of bullous lesions, and with fever and chills.

DR. P. A. MORROW said he had never before seen a case of erythema confined to the palms. So far as the tendency to repeated recurrences of erythematous lesions was concerned, he could recall one case in which the patient had many attacks, extending over a period of about ten years, and always succeeded by a rather general desquamation of the skin.

DR. C. W. ALLEN said that in certain cases erythema multiforme, like urticaria, seemed to owe its recurrence to the ingestion of certain articles of food and derangements of the alimentary tract. One patient under his observation has had three attacks of circinate erythema within the past four or five years, the lesions being confined to the back of the hand and forearm. On each occasion the attacks seemed to come on after derangement of the stomach.

DR. FOX said that an attack of erythema multiforme, with very few lesions, might be unilateral, but if the lesions were numerous he would expect them to be symmetrical.

DR. GEORGE T. ELLIOT said he thought the case was a typical one of erysipeloid (Rosenbach). The slow course of the affection, its location, the want of desquamation and its general appearances all pointed toward that parasitic disease, erysipeloid. Under a 10 or 15 per cent. ichthyol application he thought it would get well in a few days. As regards its being an erythema, he expressed the opinion that there was no case of unilateral erythema multiforme on the palms on record. Erysipeloid, as an infective process, might occur many times on the same person, and, while especially prone to attack the palms and fingers, might locate anywhere on the body where the inoculation would take place. One man under his observation had had six attacks. In other cases, where the disease began on the hands, it had appeared on other parts by auto-inoculation.

DRS. LUSTGARTEN, ALLEN and KLOTZ would not agree with Dr. Elliot's diagnosis. Dr. Lustgarten said that erythematous lesions on the palms were not of such rare occurrence. Erysipeloid occurred almost always among people who had to handle offal from the kitchen, etc. In this case the presence of erysipeloid was rendered most improbable by the fact that both palms and soles were at different times affected, that the process started from several foci at the same time, that it remained confined to volar and plantar surfaces without ever extending to the dorsal parts or to the fingers and toes.

DR. H. G. KLOTZ said he has observed a number of cases of erysipeloid in cooks and persons who handle meat, etc., and the lesions in those cases materially differed in their clinical appearance from that in Dr. Sherwell's case. In erysipeloid the rim was more elevated and sharply defined, and the lesions were not so regularly annular in outline.

DR. SHERWELL closed the discussion. He said it was his belief from the beginning that the lesions in this man's case were due to a neurosis, inducing vaso-motor spasm, as we found in other erythematous affections. He did not think they were due to an infectious process; it would in this latter case surely have invaded other regions. His own diagnosis of the case was erythema annulare.

**A Case of Syphilis with Unusual Features.**—Presented by DR. H. G. KLOTZ.

The patient, a female, aged 30, gave a distinct history of having had chancres and syphilis about five years ago, for which she was treated with inunctions at Charity Hospital. The present eruption is said to have begun to develop about eight or nine months ago. On the right arm and wrist there were several large papulo-tubercular patches of undoubtedly syphilitic character without any unusual features. On the nose, densely covering both sides, and on the cheeks numerous sharply defined, elevated, almost semi-globular lesions were present with smooth, almost shiny surface, of a dark red, almost cherry color, showing a different degree of consistency, some being quite soft, giving the impression as if they contained some fluid or semi-fluid substance. The peculiar distribution of the lesions, their color and principally their consistency made the case an unusual one.

Some of the members present doubted the diagnosis of syphilis, the appearance and consistence of the lesions being so different from what was usually seen in syphilis.

DRS. MORROW and SHERWELL called attention to the resemblance of the lesions to those of lupus; the former thought there was a lupoid element in the lesions. The length of time, eight or nine months, the eruption had existed, according to the patient's statements, seemed entirely different from the history of a syphilide, with or without treatment, to Drs. Morrow and Cutler. Probably the statement of the patient could not be considered reliable.

DRS. CUTLER, MORROW and ELLIOT thought that a microscopical examination would be necessary to make a positive diagnosis, Drs. Cutler and Elliot suggesting the possibility of a colloid degeneration on a syphilitic base.

DR. SHERWELL said the diagnosis could be rendered positive by the use of specific remedies.

DRS. LUSTGARTEN, BRONSON, FORDYCE, FOX, ALLEN AND ROBINSON had no doubt of the syphilitic character of the disease and did not require any further proof.

DR. FOX said the bright color and the appearance and consistence of the nodules on the face were somewhat unusual; still, those conditions are occasionally seen in the tubercular syphilide.

DR. BRONSON thought the peculiarities of the eruption were probably due to the soil in which it was developing. The lesions differed from the ordinary papular syphilide, and were more like gummata of the skin.

DR. FORDYCE said we not infrequently saw syphilitic gummata which had this bright color. In one case he saw the lesions were almost black. The darker or lighter color depended upon the extravasation of the coloring matter of the blood. The progress of the lesions had been too rapid for lupus.

DR. ALLEN called attention to certain coppery-colored spots on the woman's forehead, which he thought were probably the result of lesions which had shrivelled up. He said he would not hesitate to pronounce the case one of syphilis of unusual form, and it illustrated what a great simulator syphilis could be.

DR. KLOTZ said he did not think it very unusual that a papulo-tubercular syphilide should last for so long a time. The color of the lesions, too,

he had occasionally met with in syphilis; it was their consistency that undoubtedly constituted the most peculiar feature of the case.

**A Case of Eczema Affecting the Nails.**—Presented by DR. MORROW.

The patient was a young man with eczematous lesions of a papular character, confined to the dorsum of the hands and fingers, with marked changes in the nutrition of the nails. The disease had existed for eighteen months in a very aggravated form. The nails of the middle and ring fingers had been entirely shed. The palms remained entirely free from any eczematous manifestation.

DRS. BRONSON, FORDYCE and ROBINSON considered the case one of ordinary eczema, the two former remarking that the eczematous process had invaded the matrix of the nails and thus impaired their nutrition.

DR. CUTLER said he was rather inclined to think that the case originated as one of scabies, which disappeared and was followed by the eczematous lesions on the hands. A similar case recently came under his observation.

**A Case of Erythema Multiforme, Simulating Variola.**—Reported by DR. SHERWELL.

The patient was a man who presented a generalized papular eruption of the neck and buttocks and about the wrists, the face being exempt. The eruption was very much like that of variola in appearance and feel, with very slight increase of temperature, so much so that at the first examination the diagnosis was reserved. Within twenty-four hours, however, the typical lesions of erythema multiforme developed.

DR. FOX referred to a similar case which he had seen at the Willard Parker Hospital.

DR. MORROW exhibited a photo-micrograph made by Dr. Fordyce, showing a section removed from one of the lesions in a case of *molluscum contagiosum*. He also exhibited a small *falciform curette*, which he had found admirably adapted for the removal of these lesions. Over 250 small tumors had been distributed in this case over the abdomen, the cheeks, arms and back, a few on the penis and legs. They had all developed within four months. The growths were so numerous that it was impossible to remove them by electrolysis. With this curette the work can be done with the utmost facility. At the first sitting over sixty of the tumors were removed, and the remainder in two sittings. Up to the present time none of them have recurred.

DR. CUTLER said that in women and children, who were timid about an operation that involved cutting, the tumors in these cases sometimes rapidly disappeared after slight cauterization by puncturing them with pure carbolic acid and then covering them with a small piece of mercurial plaster.

DR. ALLEN said he did not think we can apply the term "cutting" to the operation of removing these tumors. He has removed some which were quite large by expression or by scraping them. He stated that if the tumors are entirely removed they do not recur, provided the patient is not brought in contact with some one else who has them.

DR. SHERWELL said in one case of *molluscum contagiosum* coming under his care the patient had an enormous mass of confluent tumors on

one side of the face. It was impossible to scrape them. He applied carbolic acid in fair strength, followed by mercurial plaster, and the lesions healed with little or no scarring.

DR. KLOTZ said that for a number of years past he has treated these lesions by puncturing them with a sharply pointed toothpick saturated with a 50 per cent. chromic acid solution. He does not apply anything afterward, as the lesions remained perfectly dry. He has used this treatment when the lesions were on the eyelids of small children, where it is not easy to use cutting instruments.

DR. MORROW said he used carbolic acid and silver nitrate in previous cases, but it required some time to make the applications, and eventually gave rise to more severe pain than does scraping. With the small curette the work could be done much more quickly. An interesting feature of this case was that he had been able to watch the progressive development of the lesions in different parts of the body.

DR. ALLEN said he had been able to watch the development of two of these tumors which appeared side by side on his own hand after operating on a case. At first each looked like the prick of a needle, which gradually developed into a growth about half the size of the head of an ordinary pin, in spite of the frequent washing to which the hands were subjected and of the use of antiseptics. The diagnosis was confirmed both clinically before removal and microscopically afterward.

DR. MORROW gave the history of a patient on whose body over eighty small vascular warts developed during a period of two or three months. They were most abundant over the abdomen, chest and arms. He attempted to remove them by electrolysis, but the patient was so exceedingly sensitive that that method was abandoned and he used the curette instead. There was very little bleeding.

DR. SHERWELL referred to a case of typhus fever that came under his observation a few days ago; the eruption was slight, but distinct and characteristic.

DR. MORROW inquired whether any of the members present had any experience in the treatment of psoriasis with thyroid extract?

DR. LUSTGARTEN said he had employed the thyroid extract in different cases. In one case of psoriasis it produced symptoms of nausea and palpitation, and had to be stopped. The preparation employed was that of Parke, Davis & Co., which is very efficacious. His experience was as yet too limited to form conclusions.

DR. FOX said he had carefully perused the reports in the English journals regarding the treatment of psoriasis with thyroid extract, and he failed to see that the slightest proof was adduced by the writers that the remedy possessed any value whatsoever in those cases. The patients were put in a warm bed in a hospital, their diet was corrected and some of them were discharged cured, or nearly cured, from three to five months later. Probably just as good results could have been obtained in those cases by giving them bread pills or anything else instead of the thyroid extract.

DR. ELLIOT said he had known of the thyroid extract being used in a number of cases, but without any good results. The glycerine solution prepared by Dr. Cray had been used.



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## Original Communications.

### THYROID FEEDING IN DISEASES OF THE SKIN.<sup>1</sup>

BY

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THE wonderful efficacy of thyroid feeding in myxœdema and cretinism is so well attested that there can be no doubt about it. The discovery of this method of treating these diseases may well be reckoned among the most noteworthy of the advances in modern therapeutics.

In myxœdema we find that the skin is dry and scaly, the hair is lost from the scalp and other hairy parts, and the nails are more or less deformed. Under thyroid feeding it was observed that the skin ceased scaling and resumed its normal appearance; that the hair grew again, and that the nails became once more sound. From this it was argued that thyroid feeding should prove curative in those diseases of the skin in which there is dryness and scaling. Psoriasis, eczema, dermatitis exfoliativa, ichthyosis, have all been subjected to thyroid feeding, and reports of cases have already appeared in the medical journals. In rosacea one case, and lupus vulgaris two cases, the remedy has been tried and results reported.

What it is in the thyroid that produces the results obtained we as yet have not discovered. That in myxœdema thyroid feeding furnishes something to the body that the degenerated or changed thyroid proper to the patient has ceased to furnish

<sup>1</sup> Read before the American Dermatological Association at Washington, D. C., May, 1894.

is a rational theory of its action and basis for its use. I believe that physiologists are by no means agreed as to the functions of the thyroid. Forbes<sup>1</sup> suggests that thyroid feeding benefits skin diseases by increasing the hæmoglobin of the blood, and by stimulating and regulating both the neurotrophic and the trophic centers for the skin. Of course this is pure theory. It has the advantage of sounding well; and the disadvantage of giving us no more positive information than that often-used term "trophoneurosis," behind which cloak we frequently endeavor to hide our ignorance of the etiology of a disease.

The action of the thyroid upon the skin is sometimes very marked, especially after large doses. Thus in a case of Dr. F. J. Smith, mentioned by Davies<sup>2</sup> after the accidental ingestion of ten thyroid glands at one sitting there was an acute dermatitis with exudation of a peculiar sticky secretion saturating the skin, which was followed by entire peeling of the skin of the hands. In moderate doses exfoliation is at first increased, and then lessened.

Unfortunately the administration of the thyroid is attended by more or less danger to the patient's life, several sudden deaths from its use having been reported, and a still larger number of cases in which most serious symptoms suddenly developed. It seems to exert an inhibitory action on the heart, causing faintness, palpitation and rapid irregular pulse. There is generally a rise of temperature, sometimes very marked, when the article is at first administered, and afterward when the dosage is increased, or even without increase. Headache, nausea, vomiting, diarrhœa, marked loss of weight, have all been noted from its use. As we are still in the experimental stage, it is not possible to speak definitely of the dosage. Various methods have been employed to introduce the thyroid into the economy. At first the sheep's gland itself was eaten cooked in various ways. Subsequently a glycerine extract, a desiccated powder, and compressed tablets of the powder or extract have been prepared for our use. The powder and tablets have been most used thus far, and the initial dose for an adult may be placed at three to five grains two or three times a day. I found in one case that three grains three times a day was all the patient could take. As much as thirty-five or forty grains have been taken during the day. In all cases the patients must be carefully watched. It seems to me that the best method of

<sup>1</sup> *Med. Times and Gaz.*, 1894, XXII. 136.

<sup>2</sup> *Brit. Jour. Dermat.*, 1893, V. 257.

using the thyroid is by putting up the powder in gelatine capsules. They are much more sure of being absorbed by the stomach than are compressed tablets, and in them the dose may be exactly regulated.

My own experiments with thyroid feeding are limited to five cases, and are presented now because it is desirable that as full reports as possible should be made as to the action of every new remedy, no matter whether the results are favorable or unfavorable. My first three cases were of xeroderma, my fourth was ichthyosis, and my fifth was dermatitis exfoliativa. All but the last case were treated as ambulant patients.

No. 1.—Minnie R., aged 24, single; November 20, 1893. Xeroderma. The skin of the arms, legs and trunk is dry and scaly. Face and scalp are slightly scaly. The scaling is most marked on the chest. The general health is good. She was given one grain t. i. d. of Parke, Davis Co.'s desiccated thyroid put up in capsules.

November 23d. Has caused no disturbance of health. Increase dose to two grains t. i. d.

December 2d. Skin softer and seems less harsh and dry. Complains of frontal headache beginning in the morning and lasting until the afternoon.

January 13, 1894. Has been in house for several weeks with bronchitis, and has taken no thyroid. Shortly after stopping the medicine the skin began to peel off in large flakes. Now the peeling has stopped. Renew thyroid at two grains t. i. d.

January 23. Soon after commencing the thyroid she had a return of her frontal headache, which is one of soreness. Arms and upper chest are smooth. No change on the legs.

This patient was confined to the house for the rest of the Winter with chronic bronchitis, and the experiment was never resumed.

No. 2.—Maggie R., aged 22, single; November 23, 1893. Xeroderma. Sister of No. 1. Most marked on limbs. Face and hands trouble her a good deal in Winter time on account of being so dry and cracking. Gave two grains of thyroid, desiccated, t. i. d.

December 12th. No change. No constitutional disturbance. Increase to three grains t. i. d.

December 21st. About four days after taking last-named doses she had a severe headache on top of her head that has

continued until now. Directed her to stop medicine for twenty-four hours, and then begin again.

December 27th. Headache stopped when medicine was stopped, and has not troubled her since, though again taking the medicine. Continue treatment.

January 4, 1894. Comes with an acute, intense, general erythema. Complains of burning of the skin. This began four days ago. Skin is softer and smoother. She thinks that her legs are more scaly than usual. Continue treatment.

January 13th. Erythema faded soon after last visit. Skin about the same. Increase dose to five grains t. i. d.

January 23d. Report that last dose nauseated her and made her feverish, so stopped medicine for past week. Says that her skin is softer than usual at this time of year. To take no medicine for one month.

March 9th. The skin is rougher than before she stopped taking the medicine, though the weather is warm.

This patient took the thyroid for another month and then we agreed that there was no use in continuing it longer.

No. 3.—Louise S., aged 16, single; October, 1893. Xeroderma. This patient might almost be called an ichthyosis case. She was referred to me in consultation by Dr. D. Magie, of New York. Under his oversight she took the glycerine extract as made by Dr. G. W. Crary, in three to five drop doses. The medicine gave her lightness of head and a general tired feeling, so that it had to be discontinued. As these symptoms ceased when the medicine was not taken, and returned shortly after it was again exhibited, there is little doubt about the connection between the two. The skin was not benefited.

No. 4.—Maria B., aged 12; November 29, 1893. Ichthyosis. This was a very pronounced case showing the blackish tessellated arrangement of the epidermis over the extensor aspects of both elbows and knees; some ectropion; fingers flexed on palms; palms cracked and bleeding. She was put on the desiccated thyroid three grains t. i. d.

December 18th. Is taking ten grains per day.

December 27th. Patient says that she feels more comfortable. Little change noticeable in the skin, though perhaps it is a trifle softer, and hands more supple. Dose increased to four grains t. i. d.

January 13, 1894. Increase dose to five grains t. i. d.



February 14th. Dose has been gradually increased to six grains t. i. d., with no apparent improvement.

March 21st. Has taken no thyroid since last seen. Does not feel so comfortable as she did when she was taking it, as she has more itching. Give thyroid again in three grain doses t. i. d.

After this time the patient ceased attending at the dispensary.

No. 5.—Mrs. J. S. R., aged 48. Married. March 17, 1894. Dermatitis exfoliativa.

This patient was sent to me in consultation by Dr. J. G. Smith, and was admitted on my recommendation into the Presbyterian Hospital, on March 21st, where she has been under careful watching up to the time of writing, May 15, 1894. Thanks to the courtesy of Drs. W. H. Flint and W. G. Thompson, I have had ample opportunity for studying the case, and for using the notes kept by the staff.

Family history: Her brothers have eczema. Her mother died of paralysis and one brother died of phthisis.

Previous history: Has had one living child, and two miscarriages. Menopause last Summer. Has had several attacks of eczema during the past three years, appearing on different parts of the body. Is asthmatic. Her bowels have been regular.

Her present disease began in the latter part of December, 1893. It began on the arms and spread rapidly from there all over the body. Her hair soon fell out from all over the body, and the whole surface of the body became scaly, so that her bed would be full of scales in the morning.

March 21st. On admission to hospital the whole surface of the body was red, dry and scaling abundantly, the scales being thin and readily separating on lightly rubbing. There was absolutely no moisture anywhere nor cracking over the joints. The skin was but slightly thickened, and showed no excoriations from scratching, although the patient complained of intense itching. There was no hair anywhere on the body. The nails were thickened, striated and broken. Patient is chilly all the time. Bowels constipated. Tongue clean. Appetite good. Is thirsty all the time. She says that she urinates only twice in twenty-four hours.

The urine showed neither albumin nor sugar. Sp. g. 1025. Some leucocytes and mucus.

Temperature, 99°. P. 102, R. 16.

She was put on a fluid diet; given a laxative pill; and

ordered a soda bath every other day followed by the free use of vaseline. She was also given thyroid extract, fluid, two drops t. i. d.

March 25th. Temperature  $100\frac{1}{2}^{\circ}$  in the afternoon.

March 26th. Temperature  $103^{\circ}$  in the afternoon. Pulse 122. She now developed an attack of erysipelas of the scalp, which became swollen and boggy. The thyroid was stopped, and lead and opium wash used.

April 9th. Erysipelas subsided. Gave thyroid tabloids, English, five grains, A. M. and P. M.

April 10th. Temperature  $97^{\circ}$  in the morning.

April 12th. Thyroid increased to five grains t. i. d.

April 14th. Temperature remained subnormal until to-day, when it ran up in the evening to  $99\frac{3}{4}^{\circ}$ .

April 15th. To-day the whole surface of the body suddenly became soft and moist as if profusely sweating. The finger-webs became white and soggy like those of a hand long immersed in water.

April 27th. Temperature rose to-day from  $98^{\circ}$ , to  $100\frac{3}{5}^{\circ}$ , the dose of the thyroid having been increased to 6 grains t. i. d.

April 29th. Temperature reached  $99\frac{2}{5}^{\circ}$  to-day for a short time, and then gradually fell to  $97\frac{1}{5}^{\circ}$ .

April 30th. Temperature again rises to  $100\frac{1}{5}^{\circ}$  in the afternoon.

May 1st. Temperature  $101^{\circ}$  in the afternoon, pulse 118

May 2d. Temperature  $100\frac{1}{2}^{\circ}$  in the afternoon. Ordered daily soda baths.

May 3d. Temperature  $100^{\circ}$ , pulse 100.

May 4th. Temperature  $99\frac{3}{5}^{\circ}$ .

May 6th. Temperature  $101^{\circ}$ . Pulse 88.

May 7th. Temperature  $100^{\circ}$ .

May 8th. Temperature  $100\frac{1}{5}^{\circ}$ .

It is noticeable on the temperature chart that the temperature always rises toward the afternoon, and is subnormal in the morning.

May 15th. As there is no positive improvement to-day after eight weeks of thyroid treatment it is abandoned.<sup>1</sup>

In these five cases we met with these untoward and undesirable symptoms: Headache more or less severe and continuous even with a dosage of two grains of the powder t. i. d.; intense erythema, nausea, vertigo, lassitude, rapid pulse, and sharp rise of temperature.

<sup>1</sup> As soon as the administration of the thyroid was stopped this patient made a rapid recovery. In six weeks she was discharged cured, excepting the hands and feet.

As favorable action of the thyroid we saw increased scaling, moisture and suppleness of the skin.

Up to May 1st I have found only thirty-three cases of thyroid feeding in skin diseases reported in medical journals, most all English, as will be seen by a glance at the list of references below. These may be tabulated as follows:

Psoriasis	26 cases	10 cured. (1 relapse in one month.) 7 improved. 9 no change.
Xeroderma	2 cases	both improved. Scaling lessened, and perspiration increased.
Eczema, chronic	2 cases	1 cured; 1 no change.
Lupus vulgaris	2 cases	both improved. One has taken the drug more than a year.
Rosacea	1 case	no change.

Let us add to these the five cases reported by me now, namely:

Xeroderma	3 cases	2 improved. 1 no change.
Ichthyosis	1 case	very slight improvement.
Dermatitis exfoliativa	1 case	no change.

Thus up to May we have thirty-eight cases, with eleven cured, fourteen improved, and thirteen no change. When we remember how easy it is to see an improvement when we are looking for it, it is probable that we should discount the number reported "improved."

From the few cases thus far published it would be foolish to draw conclusions. Personally I am not inclined to experiment further with this line of treatment. To cure ten cases of psoriasis out of twenty-six is no great thing to boast over, specially in hospital practice, as were most of the cases cured. When you take into consideration that the drug, in whatever way you exhibit it, is liable to produce sudden distressing and grave symptoms, *that* at once bars it from use in out-patient, ambulant practice. We surely have many other safer methods of treatment in hospitals that yield more brilliant results than this method, so efficacious in myxœdema and cretinism. In these diseases it is worth while to run a risk as to life in the hope of removing symptoms that make life hardly worth living. In dermatoses, on the contrary, life is, generally speaking, little endangered, and we are not justified in resorting to too heroic measures.

14 East Thirty-first Street.

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## STONE IN THE BLADDER ; CHOICE OF OPERATION.

BY

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AS you will readily understand from the limited nature of the subject of this paper, dealing, as it does, with a small section of a large question, it will necessarily be short. So much has been written within the past few years upon stone in the bladder, and the best means of disposing of it, that little remains to be said. Yet is it within the province of the hospital surgeon to modify somewhat—for himself, at least, the rules meant for general guidance.

The surgeon most practically familiar with the subject of stone in the bladder has occasionally met with this difficulty: not what is the best operation to be performed in cases of stone in the bladder generally, but what is the safest and best operation to be performed in *this* instance? Every case has its own individuality; and these are cases to which the general principles, or precepts, enunciated by surgical writers can with difficulty be applied. The question of age commonly comes first, and QUOAD that element, the relative advantages of lithotrity and some forms of lithotomy have been practically settled.

In both directions the limits in point of age have been greatly extended by the lithotritist, and very *young children* and very *old men* are now being subjected to the crushing operation.

Contraction of the urethra, in any part of its course, is no longer an obstacle to, but a delay merely, in the use of the lithotrite.



The condition of the bladder is now no longer taken so much into consideration as formerly : the rule once laid down, that unless the patient can retain his urine a certain period—say a couple of hours—he should not be subjected to lithotrity, no longer holds. My most satisfactory cases have sometimes been those in which the patient could not retain his urine five minutes, and in some instances the sufferer was obliged to wear a caoutchouc bag into which the water trickled drop by drop.

Whatever the quality of the urine may be, there is no hindrance on that account to the crushing operation. The claim formerly put forward for the superiority of perineal lithotomy, and revived in recent years in favor of the suprapubic method, in cases of renal complications, does not appear to me, in either instance, to be well founded. I venture to say, in general terms, that in diseased bladder, in diseased kidney, and in cases of unhealthy urine arising from either, the lithotrite is as safe an instrument as the lithotomist's knife. Nor should an attempt at the removal of a stone from the bladder be delayed pending an effort—usually fruitless—to improve any of those conditions.

The limits as to the size of the stone treated by lithotrity are becoming greater and greater, as instruments are becoming more and more perfected.

The hardness of the stone does not now seem to be an insuperable obstacle to an attempt at its reduction, as “Coming events cast their shadows before” it is not impossible that, at this meeting, a Philadelphia surgeon may so instruct us to measure the force of resistance of the calculus, on the one hand, and the crushing power of the lithotrite on the other as to establish the limits within which the crushing of a calculus may be carried with safety.

But while the sphere of lithotrity is steadily extending, and that of lithotomy is becoming more and more circumscribed, there are met with, from time to time, and in all probability ever will be met with, cases where cutting must necessarily be resorted to ; and then comes the question—which of the many cutting operations should be selected. (I may here observe, parenthetically, that all cutting operations being equally practical in any given case, the lateral method, to my mind, still possesses greater advantages and fewer disadvantages than any other.) But the lateral method is not always practicable. When an enlarged prostate or a tumor so interferes with the manipulation of the lithotrite as to make it impossible, not

only to seize the stone, but to establish its size, it appears to me to be more prudent to act as if the stone were of large calibre, too large, indeed, to be removed with ease or safety by the lateral operation, and to resort at once to the suprapubic method. Although elsewhere noted, I have removed by this method stones of much larger size than is deemed advisable by many to undertake by the lateral method I am free to admit that, in stones over a certain size and in stones the size of which cannot be clearly made out, the suprapubic method is the better.

Having said this much, I venture to express, in a few words, a few general principles, or aphorisms, most of which have already been accepted by surgeons, and to offer an additional one for your acceptance. (I.) Lithotrize—and by lithotrity I mean that more perfect method, which was foreshadowed by Mercier, in France, and brought to its highest perfection in America—lithotrize in all cases of adults where the stone is neither too large nor too hard for the lithotrite. (II.) Lithotrize where the urethra is, or can be made sufficiently capacious for the crushing instrument. (III.) Lithotrize in children, however young, where the urethra can permit the passage of a crushing instrument. (IV.) In very young children the cutting operation is preferable. The precise age at which lithotrity is possible must vary with the calibre of the canal, which in young children greatly varies in its capaciousness and in its capacity. When the urethra in the child is not and cannot be made fit to receive the lithotrite, the cutting operation to be chosen is the lateral method. (V.) In cases of stone in the aged, where enlarged prostate not only prevents the stone being seized, but its dimensions being ascertained, we should act as if the calculus were of large size, and incapable of reduction, and proceed to operate by the suprapubic method. I must confess that I have been forced to this conclusion by the consideration of two somewhat untoward cases of recent date where, prevented by an enlarged prostate from grasping the calculi, I adopted the lateral method, and found it impossible in both cases to complete the operation without reducing the volume of the stone before extraction—a procedure which it is always advisable to avoid when possible.<sup>1</sup> The consideration of these cases has led me to reconsider certain rules. I ventured several years ago to lay down to influence surgeons in the choice of operation, and it is

<sup>1</sup> In both these cases the suprapubic method would have been better.

the views then expressed, I should wish, with your consent, to modify. Surgical interference in cases of calculus in the female remains the same. The method employed, years ago, by Erichson, Thompson and others, has since been followed, and stones of large size are removable generally, *per vias naturales*, after dilatation. In exceptionally large calculi the lithotrite commonly suffices, and rarely, indeed, is the surgeon obliged to resort to the knife in the case of females.

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A CASE OF FAVUS OF THE HEAD AND BODY.<sup>1</sup>

BY

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(Concluded from page 385.)

(*b*) *Cases of favus located on the hairy and non-hairy portions.*

**A**LIBERT recorded the case of a woman, *æt.* 68, who showed, in addition to favus of the scalp, other crusts on the arms and thighs. Three other cases are also described by Alibert, two of which occurred in sisters who were Italians, aged respectively 5 and 7 years, showing favus of extreme severity upon the scalp, patches of disease on the eyebrows, temples, shoulders, lumbar and sacral regions, external upper part of the thigh and about the middle of the legs. The eruption occurred in the same localities in both children. The other was observed in a Frenchman (age not given), affecting the scalp, while numerous lesions were also present on the chest, abdomen, thighs, legs and arms.

Of the remaining cases, one is described by Roddick, of which he also gives a picture, of a girl, *æt.* 10, in whom the disease has existed for five years, then attacked the neck, spine of the scapula, upper part of the outside of the arm, forehead, abdomen, back, buttocks, anterior surface of the legs from hip to ankle, down the legs posteriorly and a large share of the front and side of the body as well. The eruption extended almost to the hands and feet.

The following cases, fourteen in number, developed first on the hairy scalp and subsequently spread to the non-hairy parts. Kleinhans speaks of the case of a young man suffering from favus of the scalp for eleven or twelve years; later the disease extended from the scalp to the face, and three favic scutula of different sizes occupied the left superciliary region.

Michel, in his report of a case of favus in a woman of 45, stated that the disease had existed forty-four years, being twenty-six years on the head before attacking the body. It first affected the axilla, then the breast, abdomen, hips and thighs. After removing the crusts the surface appeared red, with slight depression and covered with aqueous fluid. There was a spontaneous cure of all affected places after being delivered of a child; but within one year a relapse occurred.

In an extensive case, described by Baumgarten, the disease existed primarily on the head of a boy aged 17; after being in this locality for five years it extended gradually over the body, some of the crusts being the size of a nutmeg. The more recent of these were conical in shape, one-half to three-quarters of an inch in height, and of still larger size, others being of the circumference of a half-dollar. Some had dried and become fissured and warped so as to allow one to place a finger under the margin, when the crust could be easily removed, showing the skin beneath to be depressed, humid and of a dark color. At the beginning the spots were the size of a pin-head and increased by confluence, or upon the periphery. The crusts were always dry; no pus at any time. Face, hands, feet and neck were free; back, arms and legs were covered with thick crusts; anterior surface not so marked. In this position a number of pigmentations were noticed which were left after a former attack of greater dimensions. He also speaks of a case (described by Dr. Engelmann seven years before) in which the crusts were small, the size of a pea, but flat and thin. The disease, which affected one side of the face and head, was communicated to the patient from his wife, who had favus of the head.

In Galliard's case, a woman, æt. 20, gave the history of having contracted favus at the age of 10, which remained untreated for nine years. The disease gradually spread to the back of the hands and wrists; some time later it appeared on the knee, and later still on different parts of the body, invading the face. When examined the patient was found to be in an extreme state of debility and anæmia; there existed lesions of



various kinds, some due to the original disease, others of a purulent character due to irritation, partly the result of pediculosis. The entire scalp was covered with crusts; the face showed at least thirty lesions of a highly characteristic description; some also existed on the neck, while the arms showed lesions circinate in development. There were also a few isolated lesions on the right hip and thigh.

The case presented by Kaposi and Kundrat to the Society of Physicians of Vienna on November 28, 1884, is regarded as decidedly unique, and gave the following history: It occurred in a man, æt. 40, at first on the head, the lesions being noticed on the upper eyelid toward the malar eminence; there were eight or ten scutula which were punctiform and of pin-head size, and one larger scutulum. The extensor surfaces of the upper and lower extremities were covered with almost uniform pin-head sized lesions, the margins being erythematous. On the trunk near the nates, the lesions were irregular and disseminated, some being found in small groups. In three weeks the case became universal on the skin of the trunk and face, shoulders, knees, hands and buttocks. In many places circumscribed depressions were found, which were opaque and discolored. The patient succumbed to gastro-intestinal irritation accompanied by uncontrollable diarrhœa. At the post-mortem numerous erosions and diphtheric swellings, resembling favus cups, were found in the mucous membrane of the stomach. When examined with the microscope the swellings were said to be due to the achorian.

Wickham refers to a case affecting both the scalp and the lower limbs; the plaques situated in the latter region were upon the anterior surface of the thighs, the knees, and the lower legs, those in the last-named locality extending, as they passed downward, over the lateral and posterior surfaces.

One other interesting fact in connection with the case reported by Wickham is that the man had the disease twenty-nine years before it attacked the body; since these parts were first affected, six months ago, the progress of the eruption has been very rapid.

Following this writer, Morris describes an extensive case of favus in a woman 37 years of age, which began fourteen years ago, as a small red sore on the head. A great portion of the back was covered with large masses of crusts. The nails of both hands and feet were affected, particularly those of the first finger of each hand, and the great toes. On microscopical ex-

amination, the lungs showed tubercular infiltration, but not the presence of the favus parasite. Still later, we find a report of three cases by Dubreuilh and Sabrazès, the first of which occurred in a boy, *æt.* 8, in whom there existed a typical favic scutulum on the right parietal protuberance, and an impetiginous favus plaque on the occiput. Three months later favus lesions appeared on the surface, one on the nucha, four on the right jaw, one on the upper lip, one in front, and below the chin, one on the end of the nose, and one between the eye brows.

In another case, a girl, *æt.* 3, the hairy scalp had been the seat of favus lesions for fifteen months. On the forehead two well-defined plaques were present, about the size of a twenty centime piece. On the right cheek two similar plaques the size of a pea were noticeable, and on the bridge of the nose a similar lesion of the same size.

In a third case, a boy, 10 years of age, who had contracted favus of the scalp at an indefinite period, there appeared several months later a plaque on the right temple, two on the right half of the forehead; one of the latter was situated 1 ctm. from the border of the hair. His mother stated that analogous lesions, which had existed previously on the right cheek, had disappeared without treatment.

Three cases, which were probably contracted from a cat, and observed by Crocker, were witnessed in a poor and very dirty family.

*Case I.*—A girl, *æt.* 7, besides having the disease on the scalp, showed patches on the shoulders and arms.

*Case II.*—(Brother of Case I.) *Æt.* 9; the disease began in front of the ear, and within a month involved the entire head; it had appeared on the arms about the same time, having existed on the thigh for only one month. The largest isolated patches were the size of an ordinary pea, and the compound lesions two inches in diameter.

*Case III.*—Another brother, *æt.* 11½, had the disease one month, it being confined to the right parietal region.

The preceding writer also gives a case in which Hutchinson found the hair of the entire scalp destroyed, which persisted as a large scar. Lesions were also observed upon the face and fingers, while conspicuous crusts were seen over the body and limbs; none of these resembled favus, but the fungus was observed with the microscope.

In the following cases, numbering seven, the primary seat of the disease was not particularly mentioned.

Gull's case occurred in a young man, æt. 20, who was stunted in growth, and had the appearance of a boy of fourteen years. The disease was of fourteen years' duration, and affected the arms, scalp, forehead, temples, trunk and lower extremities. The crusts were nearly circular, the hair growing through some of the largest cups, one of which was two inches in diameter, elevated, and appeared to be formed of concentric rings, getting broader toward the base. Many of the crusts were cracked in all directions. There was a small lesion under the margin of the nail of the left ring finger; the nail was in part destroyed. If the crusts were removed from the body surface the part beneath was tender, but not ulcerated; if they were pulled off before being perfectly mature the skin would bleed.

In a case reported by Duckworth, in which the entire scalp was affected, and marked thinning of the hair existed, the disease was also witnessed on the arms and legs, in small patches, and presented scars of a former attack of the eruption. The disease was said to have been cured at St. Bartholomew Hospital, but it returned. The cervical glands were decidedly enlarged.

We find a case reported by Morrow, in a boy, æt. 13, who had been affected with favus for nine years. The father had married twice, and the children of the first wife had been given to a nurse several of whose children had the disease on the scalp. The children of the father's second marriage contracted the disease from this boy. They all recovered except this one, who upon examination showed favus upon the head, the left upper arm, lateral surface of the thighs and legs below the knee, and the internal surface of the buttocks near the anus. The patient indicated various other portions of his body which had been formerly occupied by the disease, but from which it had disappeared.

Pick describes two cases: In the first, that of a boy, æt. 14, the hairy scalp was affected; favus lesions were present in several places on the face and back, particularly over the shoulder blades. Numerous scutula had also developed on the nates and the posterior surface of the thighs.

In the second case, a man, æt. 20, who occupied an adjoining bed in the same ward, characteristic scutula appeared almost in the same localities.

In the case of a woman 36 years of age, recorded by Fabry, the disease had existed for eight years; the head was covered with numerous lesions, while scutula were observed

over the neck and right scapular region, being the size of a five-mark piece. There was marked ectropion of both upper eyelids.

Havas reported a case before the Medical Society of Budapest, affecting the head and showing isolated scutula on the trunk. Surrounding some of the smaller of these there was perifollicular inflammation, and in places a herpetic primary stage.

A number of experimental inoculations with the achorion have been performed, and a short account of some of these, with those of accidental inoculation, is appended.

Peyritsch has recently inoculated persons with favus under the epidermis without result; where the epidermis had been blistered and the favus introduced he was also unsuccessful. He was successful, however, if he introduced it directly into the mouth of the hair follicle by means of a puncture with a needle, and a drop of water in which a particle of favus had been placed for several hours and then allowed to evaporate.

In ten cases in which the experiment had been performed six were somewhat successful, as follows: Numerous scutula followed, preceded by slight formation of vesicles. In one case scutula formed and also excessive development of herpetic groups; the circles kept enlarging for two weeks after the favi had disappeared. In three cases scutula were not developed. Once only papular efflorescences were developed, which disappeared in three weeks. In another case redness and swelling of the follicles followed, which decreased on the fourth day and then increased; on the eighteenth day circles formed and were covered with scales. In one other inoculation herpes alone formed, which was followed by vesicles at the margin, and these increased in three weeks.

In an experiment upon his left arm, Van Harlingen, in 1871, scraped the epidermis and pressed some of the favus crust into the moist surface, as in vaccinating. The spot was covered with a watch-glass and secured with adhesive strips. The part was undisturbed for a week or ten days, at the end of which time a distinct yellow characteristic favus cup was seen to have developed at the point of inoculation. This was shown to the class of the University of Pennsylvania at Dr. Duhring's clinic. The following day (the 11th) the watch-glass was removed; no treatment was employed, with the exception of a daily cold shower bath, without soap. The eruption soon disappeared.



Nine or ten successful experiments have been performed on the limbs by Horand.

Bulkley inoculated the arm of one of his assistants, and six weeks later distinct favus cups appeared; there were three or four, beautifully formed, though none larger than the head of a pin, and around these a scaly erythematous halo.

After washing the parts, and shaving the right forearm, Fabry scraped the skin with a lancet, and inoculated. A few days later an erythematous circle appeared the size of a five-mark piece, and ten days later herpetic lesions; after nineteen days, five scutula, the size of half a lentil, made their appearance.

A distinct crust was observed in each case, by Pick, after inoculating seven persons with one crust of favus.

It is undoubted that many cases have been contracted by accidental inoculations, and it is a well-known fact that many of them are unrecorded; of those recorded, we quote a number:

Rayer, observed the affection in a woman (see p. 8 *et seq.*) who had contracted it from the head of her child while carrying it on the affected extremity. A woman, according to Devergie, contracted it upon her fingers after washing the head of an affected child. Another interesting inoculation, stated by Kleinhans, occurred in a woman who had syphilis and was supposed to have contracted favus upon the tip of her nose from a patient in an adjoining bed of the ward; and in addition to the case reported by the authors in which a patient in an adjoining ward contracted the disease, (see p. 6 *infra*) we find similar circumstances mentioned by Pick, and two instances recorded by Hutchinson.

Engelmann, quoted by Baumgarten, recorded the case of a man who contracted it upon the sides of the face, from the head of his wife.

St. Cyr describes an accidental inoculation on his own hand, as follows: "The epidermis, to the extent of a silver five-franc piece, is of a yellowish discoloration, thickened, corrugated and split; at the margin of this circle is situated a ring of vesicles filled with clear serum, scarcely the size of a lentil or pea. On close inspection, the lanugo hairs are seen to be surrounded with yellowish, pin-head sized scutula, which are slightly depressed in the center, and look as if they had been made with a needle."

Twenty-eight cases of children affected with favus by accidental inoculations were observed by Horand.

It may be well to mention that Alibert and Von Rossi think that before inoculation there must have been an abrasion of the part.<sup>1</sup>

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<sup>1</sup> The authors are indebted to Dr. H. W. Stelwagon, of Philadelphia, for the photograph accompanying this article.

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## Society Transactions.

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### THE AMERICAN DERMATOLOGICAL ASSOCIATION.

EIGHTEENTH ANNUAL MEETING. HELD AT WASHINGTON, D. C.,  
MAY 29, 30, 31 AND JUNE 1, 1894.

DR. GEORGE T. JACKSON, *Vice-President, in the Chair.*

*(Continued from page 399.)*

**Adino-Carcinoma of the Skin Starting in the Sweat Glands.**<sup>1</sup>—By  
DR. JOHN A. FORDYCE, of New York.

DR. WHITE said it seems impossible that an affection confined to the skin can, in one instance, destroy the whole integument in a short period of time, while in another case the same disease should run a course of twenty years or more. It is through such studies as these that we shall be able to comprehend these differences.

DR. BRONSON had examined the subject of the paper, who presented a tumor growing upon the anterior surface of the leg. It was somewhat larger than a large Spanish olive, projected prominently and was of a dusky red color. The history, so far as he could learn, was that it had been in existence for a year or two. It had the appearance of a papillomatous growth. No subjective symptoms attended it. I was surprised at the result of the examination. The peculiar features might be accounted for by the sweat-gland origin.

DR. HARTZELL thought we would gain much in clearness in our knowledge of these growths if we realize that they are all essentially the same, all being epithelial. The essential character of the epithelial cell is not changed. It continues to proliferate, continues to be of the same character as the parent cell; so that, in a growth of this kind, the cells must have had their birth in the cylindrical cells. He believed firmly in the parasitic origin of epithelioma. Just what the parasite may be we are not in a position to say; but where it is abundant the growth will proceed more rapidly. If parasites are few they, acting as irritants, will excite but moderate proliferation.

DR. FORDYCE said sweat-gland epithelioma are so rare that it is impossible to speak regarding the point raised by Dr. Bronson, but there are clinical varieties of epithelioma of the face which are quite soft. He remembered a case which one of our members diagnosed as sarcoma of the face; it was a soft brownish-red nodule. On examination with microscope it proved to be epithelioma of the glandular type.

<sup>1</sup> Will be published.



"The Question of Contagiousness of *Molluscum Contagiosum*."<sup>1</sup>—By DR. HENRY W. STELWAGON, of Philadelphia.

DR. FORDYCE said there is little doubt of the contagiousness of molluscum contagiosum. He had seen at least half a dozen instances in which it could scarcely be questioned. The speaker then showed a number of photographs taken from preparations of fresh material squeezed out of the lesions. A number of cells distinctly showed the presence of one or more round bodies which can be differentiated from the cell nucleus.

DR. HARTZELL said he was also fully convinced of its contagiousness, having so frequently seen cases in several members of a family that he cannot doubt that it was conveyed from one to the other.

As to its etiology, he arrays himself with those who believe in the etiological relationship of psorosperms to this disease. After we have examined sections in which the epithelial cells have broken down we may convince ourselves that these round bodies are quite distinct from the epithelial cells, not animal cells, but have reached the epidermis from the outside.

DR. ZEISLER said he had for a long time been looking for a case in which he could trace the contagion, but in vain. He could recall distinctly a case of a married lady who had hundreds of these little tumors over her body without transmitting the disease to her husband, who he also examined, and he could mention many similar instances.

DR. WHITE said he was willing to accept the proposition, and await demonstration in the future, that a cell which belongs to a body may infect contiguous cells. Until it can be positively demonstrated that these bodies are foreign and independent animal organisms he did not think it is necessary for us to assume that they are. There has been no positive proof that they are parasitic.

Metchnikoff has recently expressed the opinion that the statements which have been made by his colleagues in France, with regard to the parasitic nature of these bodies, are to be received with grave doubt and hesitation. I think we must await further proof before accepting the parasitic nature of these bodies.

DR. DUHRING thought that, from the vast amount of material bearing upon the so-called contagiousness of the disease, we must accept this point. He could recall no cases of his own that seemed convincing on the point of contagion. While he had seen instances of two or three cases in one family, the proof of communication seemed to be wanting.

A peculiar epidemic in an institution for children was recalled. It broke out in an extremely mild form in twelve or fifteen children within a short period, and in not one of them did it attain any considerable severity, the lesions being small and ill-defined, and was not communicated to other children with whom they came in contact. Without any treatment whatever it died out in a few months. Still, there is no reason to doubt the clinical observations, although the interpretation put upon them by some observers may be open to question. I think it well not to arrive at positive conclusions nor make too positive statements at the present time.

DR. HYDE said that, while the clinical evidence of the contagiousness is so strong, it seems that the intentional production of the disease had not yet been accomplished. He called attention to the fact that some mem-

<sup>1</sup> Will be published.

bers, including himself, see but few of these cases. Almost all the reports come from those actively interested in institutions where children's diseases are treated. He had never seen a case which was at all convincing that the disease had been communicated from one person to another.

DR. GRINDON thought it quite possible that the establishment of what may be the efficient cause of the contagiousness of molluscum contagiosum may give us some valuable hints as to the true nature of the graver trouble, epithelioma.

DR. SHERWELL had for many years regarded the disease as contagious. He thought the cases recorded in the statistics were few because consultants called to institutions failed to report them.

DR. ALLEN thought the question could be settled by clinical experience, his own opinion being that the disease is a contagious one; under certain circumstances eminently so. I cannot agree with Dr. White that because an animal parasite has never been proven to be such that we cannot assume that the body which we find has this nature. If we find that the disease is contagious we have a right to assume that there is a contagious element in the nature of an organism or parasite of some kind. The cases spoken of by Dr. Duhring are in the nature of negative evidence; for, in his experience, the early lesions do not show any great tendency to reproduce themselves in others. The disease is most contagious at a later stage. When there is present on the face of a child, for example, a large neglected tumor which has, perhaps, gone on to suppuration, others quickly spring up upon other parts of the body, and it is in this stage that the disease is most often transmitted to the breast or neck of the mother. In his own case spoken of by Dr. Stelwagon he neglected to mention that the clinical diagnosis was confirmed by a colleague, and microscopical examination proved it to be correct. It seems to me that such a case affords strong evidence of the contagiousness of the disease.

DR. WHITE said perhaps he had not made himself quite clear. While believing in the contagiousness of the disease, he said that it was possible to account for this contagious element without assuming those particular bodies to be the cause. It may be proved hereafter that cells belonging to our bodies have power of communicating a condition to other cells without the necessity of the introducing of a foreign element. We may also find that there is another germ that has never yet been seen.

DR. STELWAGON expressed his absolute conviction that the disease is contagious. Without such conclusion he could not explain the many clinical observations of apparent transmission and successful inoculation. The material of contagion we as yet know practically nothing about, and there is great difference of opinion among different observers, but the arguments against the contagiousness of the disease seem illogical. The same argument could be made with respect to ringworm, favus, or even scarlet fever and measles. The few successful inoculation experiments outweigh all the failures.

DR. FORDYCE said that the belief in the parasitic nature of the bodies found in so-called psorospormosis of Darier is not growing, while the belief in the parasitic nature of bodies found in cancer is increasing; and, so far as he knew, Neisser has not receded from his proposition that the bodies in molluscum contagiosum are parasitic.

**Ichthyosis Congenita (so-called Harlequin Fœtus)—History of a Case Still Living.**<sup>1</sup>—By DR. SAMUEL SHERWELL, of Brooklyn.

DR. ZEISLER said, as far as his experience goes, it is very rarely found that congenital ichthyosis is observed where neither of the parents has had any trouble with the skin. In almost all such cases it is hereditary.

Recently a whole family were brought to him suffering from this affection. The father had it in a most extensive degree, so that in places there was not only scaling, but dark pigmentation. The four children also had ichthyosis in a marked degree. It is rarely curable, but persistent oiling of the skin will keep the patient in an excellent condition. In the case of a young lady, the skin of whose body was very rough, he succeeded, with the assistance of oil, in keeping her skin in good condition.

DR. SHERWELL, in conclusion, stated that, as the parents' condition was good, it seemed to be simply a case in which the skin was relatively undeveloped.

**The Protozoa-like Bodies of Herpes Zoster: A Contribution to the Study of Psorospermiosis.**<sup>2</sup>—By DR. M. B. HARTZELL, of Philadelphia.

DR. DUHRING: This is a question upon which I would desist from expressing a positive opinion, but I am inclined to the view that it must be looked upon as cell degeneration.

DR. WHITE suggested that Drs. Hartzell and Fordyce be appointed a committee to investigate the subject further and report at the next annual meeting.

**Angioma Serpiginosum and Some Other Rare Dermatoses.**<sup>3</sup>—By DR. JAMES C. WHITE, of Boston.

DR. COUNCILMAN, in its discussion, said he had been much interested in the sections of the case of angioma serpiginosum made by Dr. Bowen. They had gone over the sections together, and he agreed with him in his conclusions. The case seemed to offer some points in the pathology of the skin with which he was unfamiliar, the most interesting being the evidence it presented of the retrogression of the growth. The blood-vessels seemed to be chiefly involved in the process. The growth consisted chiefly of small masses of cells in the corium; there was absolutely no alteration in the epithelial cells of the skin. The general structure of the corium showed no alteration, with the exception of these small masses, made up of cells which were unlike the ordinary granulation cells which we find in chronic inflammation of the tissue everywhere. The nucleus was epitheloid in character. The especial characteristics of the growth could best be studied in the periphery of the nodules. In the blood-vessels at a short distance from the periphery of the nodules there were evidences of proliferation of the endothelium and perithelium. In the cellular mass one could see small nodules composed of close aggregations of cells. It seemed to him that it was clear that there was in the first place a growth of the endothelium and perithelium of the vessels of the corium; at the same time there may have been, along with this, a new formation of blood-vessels. The greatest activity of growth in the nodules was seen in the very smallest and at the periphery

<sup>1</sup> See page 385.

<sup>2</sup> See page 369.

<sup>3</sup> Will appear in this Journal.

of the larger nodules. In places where the cell masses were not so thick there seemed evidence that the growths were undergoing retrogression. In those smaller masses we found very curious structures; in small spaces which we believed to be blood-vessels there were small granular masses, which appeared somewhat like some of the amœboid forms of the lower organisms, but we concluded they were not such. We made out that these small masses which occupy the centers of the cell groups were composed of confluent degenerated cells. It seemed probable that after the formation of the nodules by the proliferation of the peri and endothelium certain of the cells may have undergone degeneration by a shutting off of the blood supply, by actual occlusion of the blood-vessels by the masses of cells. Certainly, at the periphery of the larger nodules, where the growth was taking place, there was a marked change as compared with other portions of the tissue. As to the nature of the growth, Dr. Bowen and I regarded it as rather an angio-sarcoma. It does not correspond to the ordinary type of angio-sarcoma, because under that title a pathologist would mean a tumor originating from blood-vessels, and usually pursuing a rapid and fatal course. Still, this evidently is a sarcoma. It certainly is not an inflammatory growth; it originates in the blood-vessels of the corium by proliferation of both the endo and perithelium, and the small masses of cells in the nodules represent such a formation. The cells afterward undergo atrophy and necrosis, which explains the retrogression of the growth.

*(To be continued.)*

#### THE NEW YORK DERMATOLOGICAL SOCIETY.

234TH REGULAR MEETING. HELD ON TUESDAY EVENING, APRIL 24, 1894.

DR. C. W. ALLEN, *President, in the Chair.*

##### **A Case of Nævus of the Lip.**—Presented by DR. J. A. FORDYCE.

The patient was a child aged two years, with a cavernous tumor of the lower lip, which extended for some distance into the mucous membrane, and ended at the margin of the skin and the mucous membrane. During the past few months it had enlarged quite rapidly. Dr. Fordyce said his idea was to treat the lesion by galvano-puncture or by electrolysis. The child also had a small nævus on one ear.

DRS. BULKLEY, TAYLOR, ELLIOT and ALLEN were of the opinion that such cases should be referred to the surgeon for excision, Dr. Elliot defining them as cavernous angiomata.

DRS. PIFFARD, JACKSON and CUTLER stated that treatment by electrolysis or galvano-puncture was not very successful, Dr. Piffard declaring, that from reading the treatment always appeared satisfactory, but from actual experience was not. Dr. Allen reported a case of nævus of the lip extending into the mucous membrane, as cured by electrolysis, but it left a scar. The case of nævus of the vulva previously presented to the Society had greatly improved under electrolysis.

DRS. TAYLOR and KEYES had obtained good results from piercing them with a curved shoemaker's awl heated to white heat.

DR. SHERWELL recommended for the operation of nævi on the lip the use of a large lid clamp, which he had found very serviceable in the appli-



cation of the galvano-cautery in two cases of *nævi* of the eyelid, treated by him recently with very good results.

DR. PIFFARD mentioned that he and Dr. Keyes once dissected out a supposed *nævus* from the arm and found it to be a sarcoma.

**A Case for Diagnosis.**—Presented by DR. FORDYCE.

The patient was a child with two lesions, about the size of a silver dime, one on each buttock. They were symmetrically located, and both were covered by a scab. Upon the removal of one of the scabs a granulating surface was found underneath. The mother stated that these lesions had been present for six months, and were gradually becoming larger. There was no history of syphilis; there were no other lesions on the body. Dr. Fordyce said he thought the diagnosis lay between lupus and syphilis, although the lesions did not present very pronounced features of either disease.

DRS. ELLIOT, CUTLER, JACKSON and LUSTGARTEN made the diagnosis of granuloma from local infection. In reply to a question Dr. Lustgarten said that the term infectious granuloma had a wide denomination, meaning granulation tissue of known or supposed infectious nature. If we did not know the exact etiology of such a lesion, we might call it an infectious granuloma, leaving open the question if it was tubercular, syphilitic or of other nature.

DR. FORDYCE said he was inclined to regard the case as one of lupus, on account of the long duration of the lesions, and their appearance underneath the crust.

**A Case of Psoriasis.**—Presented by DR. FORDYCE.

The patient was a woman with peculiar depressed squamous lesions covering both arms and forearms and both knees, which had existed for a number of years. The case was undoubtedly one of psoriasis, but unusual on account of the marked redness and depression of the lesions. On the knees the psoriatic lesions were quite characteristic. Some of the lesions presented well-marked fissures.

DR. KLOTZ said that some of the lesions, which did not show the clear features of psoriasis, were probably the seat of an artificial dermatitis, resulting from the application of carbolic acid.

**A Case of Warts.**—Presented by DR. PIFFARD for DR. A. R. ROBINSON.

The patient was a woman with an extraordinary development of warts covering the palmar and dorsal aspects of both hands. These had existed for five years. They were gradually becoming flatter. The patient also had a few warts on the face.

DR. KLOTZ inquired what results had been obtained by the members present from treatment, as he had found the remedies usually recommended quite ineffective, particularly salicylic acid.

DR. JACKSON thought the case served to illustrate the infectious nature of warts. Dr. Lustgarten said that the large number of the warts and the manner of spreading suggested auto-inoculation. He recommended a 30 per cent. alcoholic solution of salicylic acid; so did Dr. Sherwell, Dr. Jackson salicylic acid plaster.

DRS. PIFFARD, KEYES and CUTLER reported favorable results from the external and internal use of the tincture of thuja. Dr. Piffard employs a

strong tincture, beginning with five drops and running up to a dram, three times a day. In some cases the drug proved very efficacious, while in others it had failed absolutely; it had been known to give rise to dermatitis and phlebitis. Dr. Keyes had given the tincture of thuja in tablespoonful doses; in some cases of papillomata it had undoubtedly effected a cure. Dr. Cutler reported a case in which probably over one thousand warts had been present on different parts of the body. Under the use of thuja both externally and internally, they had almost entirely disappeared.

DR. ALLEN called attention to the fact that this patient, as she informed him, had taken a great deal of arsenic, apparently without much effect.

**A Case for Diagnosis.**—Presented by DR. CUTLER.

The patient was a young woman with lesions on the tip of the nose, and on both palms. The lesions on the palms commenced about one year ago as a thickening of the skin, which gradually became worse. Unless she constantly employs some form of ointment the skin becomes fissured. The lesions on the nose first appeared about five months ago and are gradually enlarging. They consist of papules covered with yellowish crusts surrounded by a zone of redness. The patient appeared to be otherwise healthy, and presented no symptoms of constitutional trouble. There were no lesions on the feet. The fingers were gradually becoming contracted.

DRS. LUSTGARTEN, SHERWELL, FORDYCE, BULKLEY and KLOTZ were of the opinion that the lesions on the palms and that on the nose were entirely distinct; the affection on the palms was a tylosis, probably due to the patient's occupation or washing the hands with alkalies, etc. The lesion of the nose was considered to be lupus erythematosus.

DR. BULKLEY thought the affection on the nose was a superficial process which would readily disappear under local treatment. Dr. Fordyce mentioned the marked thickening of the horny layer of the skin. Dr. Sherwell observed that he found great improvement by the use of salicylic acid in solution in a case of tylosis of the palms and heels.

DR. JACKSON diagnosed the case as one of chronic eczema of the palms and perhaps also of the nose.

DR. ELLIOT diagnosed the case one of seborrheic eczema of the palms of the hands and of the nose.

DR. CUTLER said he was inclined to believe that the nose lesion was either lupus or syphilis—probably syphilis. He could arrive at no satisfactory diagnosis regarding the lesions on the hands. He did not believe they were due to the patient's occupation, for she had been doing the same kind of work for many years and the lesions first appeared about one year ago, and had gradually been getting worse during the past two or three months. The hands were usually absolutely dry. He would place the patient at once on anti-syphilitic treatment and report at the next meeting.

**A Case for Diagnosis.**—Presented by DR. E. B. BRONSON.

The patient was a female; colored, aged 40. She first came under Dr. Bronson's observation about two weeks ago, presenting a general pustular eruption. She had been under treatment for keratitis, and was taking mercury and potassium iodide, although there was no clear history of syphilis. From the appearance of the eruption when he first saw it, he thought it was due to the potassium iodide, and on stopping the drug it

began to disappear. Recently, however, it had become aggravated again. Some of the pustules were arranged in crescentic form. In certain situations they seemed to rise directly from the clear skin and were quite tense. In other places they were distinctly umbilicated. The adenopathies were more or less marked. The patient had a pustular eruption on the conjunctiva extending to the cornea, which Dr. Pooley, who first saw the case, regarded as an extension of the general eruption. He found no evidences of iritis. The patient is now taking the protoiodide of mercury. Almost all the members present considered the eruption a syphilitic one, while some thought that it was not purely syphilitic but a complication with some other affection.

DR. TAYLOR diagnosed the eruption as a miliary papular syphilide. Many of the papules on the face had disappeared, but the peculiar distribution of the lesions around the nose and mouth could still be seen. On the legs the picture was perfect. The process being an old one, many of the pustules had dried up and epithelial proliferation had occurred. The glandular enlargement and keratitis helped to confirm the diagnosis. In a case of syphilis seen with Dr. Cutler, at the New York Hospital, the perfect prototype of this eruption was observed.

He had seen many cases of syphilis where the patients had taken no drugs whatsoever in which the eruption was almost identical with that in this case.

DR. ELLIOT, who referred to a plate in Kaposi's Atlas, representing the identical eruption, Drs. Sherwell, Cutler and Jackson regarded the eruption as purely syphilitic, Dr. Keyes remarked that in some locations it closely resembled acne; it might be a mixed eruption. He and Dr. Bulkley advised vigorous mercurial treatment as a test.

DRS. FORDYCE, BULKLEY and ALLEN thought it possible that the use or the too early use of potassium iodide might have caused some of the pustular lesions independently of the specific lesions. Dr. Bulkley pointed to the difficulties of a diagnosis in the negro.

DR. KLOTZ thought that particularly the face showed evidence of a seborrhoic process, associated with that of syphilis.

DR. LUSTGARTEN regarded the eruption as an acne cachecticorum and not as syphilitic. Many of the lesions were of an acne-like character. Admitting the possibility of the presence of a mixed eruption, a complication of acne and a syphilide, he said it was often very difficult to make a diagnosis between certain forms of acne and the miliary papular syphilide. In both the characteristic grouping and pigmentation might be present, and it might be impossible to decide the question without close observation for some time. The localization of the lesions, and the apparent gradual stages from the recent pustular acne lesions to the final dark pigmented ones did not make syphilis probable. He advised the use of internal antiseptics to improve the condition of the alimentary tract; as such forms seem often to be due to auto-intoxication; for this purpose he had used for the last year creosote in crème de menthe and menthol, which on the strength of clinical and chemical observations had recently been highly recommended from Kaposi's clinic.

DR. BRONSON said that while he had been disposed to the opinion that the case was one of syphilis, the lesions, in their incipency, were very different from those of syphilis. They are distinctly irritative. Many of them

are pustular almost from the start and not attended by any infiltration whatever. With a syphilitic acne there is always some infiltration; here the lesions are purely inflammatory. Dr. Bronson said he is still in doubt whether the case is one of syphilis or not. Since the potassium iodide was stopped the patient has been taking mercury, and yet the eruption has steadily increased. The glandular enlargements may be the result simply of the pustular inflammation. The pustular lesions also involve the scalp, cornea and conjunctiva and the patient has a keratitis.

DR. TAYLOR said that iritis and keratitis accompanied the small miliary papular syphilide with greater frequency than they did any other syphilitic eruption.

**A Case of Arsenic Poisoning.**—Presented by DR. FORDYCE.

The patient was a 'longshoreman who assisted in unloading a cargo of arsenic. On his return home in the evening his face became swollen, and the next day he was attacked with vomiting and diarrhœa which lasted for thirty-six hours. There was also œdema of the scrotum and penis. At the present time the man has a small pustular eruption on the face, body, thighs and scrotum. A number of his fellow-workmen suffered in a similar manner.

Observations of arsenic poisoning were reported by several members occurring either on 'longshoremen unloading cargoes of arsenic (Sherwell), or handling hides covered with arsenic (Allen), or on farmers, who sprinkled their potato-vines with Paris green (Bulkley, Lewis), or on men working in Paris green factories (Elliot, Klotz), or in wall-paper factories (Bronson). At a time when the high-colored papers were much in vogue, it was stated that in the factories almost all the men were similarly affected.

In most instances the lesions were pustular, in a case observed by Dr. Bulkley the small pustules broke down into ulcers, which persisted for sometime. Dr. Klotz observed a number of years ago in his service in the German Hospital, several cases of partial but quite extensive gangrene of the scrotum from arsenical poisoning. He also mentioned the fact, which he thought was not generally known, that a large number of men working in arsenic factories showed perforation of the nasal septum. This had been communicated to him several years ago by Dr. M. Toeplitz of this city, who, he thought, had read a paper on the subject at the Berlin Congress. He considered it a matter of importance, since a perforated nasal septum was often considered a *prima facie* evidence of syphilis.

The parts principally affected were found on the hands, feet, the face and almost without exception the scrotum and less regularly and intensely the penis.

DR. TAYLOR said the penis and scrotum were usually involved in these cases because the men were apt to handle the parts in urinating. The same is true in scabies, and was very common in ivy poisoning.

DRS. LUSTGARTEN, ELLIOT and FORDYCE agreed with Dr. Taylor, that the involvement of the penis and scrotum was due to the fact that the men handled the parts in urinating. Dr. Fordyce mentioned that the same explanation had been given of the scrotal lesions not infrequently met with among chimney-sweeps in England; the soot gave rise to a dermatitis of the scrotum which might result in cancer.

DR. F. P. FOSTER suggested that the excessive involvement of the scro-



tum might be due to the corrugated condition of the skin of that organ, leading to retention of the poison in the folds.

DR. ALLEN said that in these cases the penis was less frequently affected than the scrotum, although more directly exposed.

DR. TAYLOR called attention to the fact that the skin of the scrotum was very delicate; more so than that of the penis.

DR. KLOTZ stated that in the cases of gangrene mentioned by him the men had been shoveling powdered Paris green, and he thought that the fine dust rising from the ground was directly conveyed to the scrotum and thus caused the poisoning.

**A Case of Ichthyosis Congenita (So-called Harlequin Fœtus).—Presented by DR. SHERWELL.**

The patient was a child which was born on December 21, 1893. On delivery it was found to be covered from head to feet with a hard, rough, fissured skin. The child presented no other abnormality. Family history negative. Both the parents of the child were alive and healthy, and they had two healthy children. Dr. Sherwell said that the greater part of the ichthyotic skin had been removed by bathing and constant and persistent inunction. The entire body was anointed once daily with cold cream, after bathing with mildly alkalized bran water, etc.

DR. LUSTGARTEN said he agreed with Dr. Sherwell's diagnosis, and was surprised that the child had survived so long. He did not believe it would live much longer.

DR. JACKSON suggested the use of thyroid extract. In one case of dermatitis exfoliativa in which he employed it the skin, which formerly was very dry, had become moist, and the patient felt much more comfortable.

DR. ELLIOT said that he regarded Dr. Sherwell's case as a comparatively light grade of the disease. It is possible, he thought, that the child would survive. A case reported by Auspitz had gotten well and also one of Frœbelius; others of lighter grades had lived though manifesting some degree of the disease.

DR. CUTLER suggested inunctions with what was sold in some of the drug shops under the name of turtle-oil.

DR. BULKLEY inquired why Dr. Sherwell had not continued the use of linseed oil.

DR. PIFFARD said that Dr. Fox's "turtle boy" lived for a long time.

DR. LUSTGARTEN said that he also had seen some fatal cases reported due to the use of thyroid extract. This extract acted as a heart poison, and produced similar heart symptoms as we saw in Grave's disease, where there was supposed to be a hyperaction of the thyroid gland.

DR. SHERWELL said he hardly expected that this child would reach maturity. The disease was congenital and severe and the child would probably die of marasmus. He had used, but discontinued, the linseed oil because he considered the disease an incurable one, and because to apply thoroughly as must be done to have curative effect it was not a very clean application. If the scales were allowed to accumulate for two or three days they became very thick.

**Report of Cases Presented at Previous Meetings.—DR. SHERWELL** reported that in his case of annular erythema, presented at the last meeting,

similar erythematous patches had since appeared on the opposite hand and on the plantar surface of feet.

DR. KLOTZ reported regarding the case of syphilide of the face that the soft, smooth, dark red lesions had become very much reduced in size under specific treatment.

DR. LUSTGARTEN said that in his case of *granuloma fungoides* he carried the arsenic as high as half a grain, hypodermically, every other day, and gave by the mouth forty drops of a 1% solution of sodium arseniat. daily, until he was obliged to stop on account of the severe symptoms of arsenical intoxication. He then began the use of injections of the toxines of erysipelas, but the patient grew worse, and he was obliged to resume the arsenic. The toxines of erysipelas did not seem to have any lasting beneficial effect.

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## Correspondence.

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### DERMATOLOGY AND SYPHILIGRAPHY IN FRANCE.

**Treatment of Tinea Tonsurans.**—I have already at some length given an account of the remarkable researches of Dr. Sabouraud upon tinea tonsurans.

After giving the natural history and the clinical history this eminent observer is occupied at the present time in studying the treatment of this disease, and it is the first results obtained that I desire to communicate at the present time.

It is well known that Dr. Sabouraud has divided the diseases previously confounded under the name tinea tonsurans, or trichophytosis, into three leading classes: 1st. Tinea tonsurans, with little spores caused by the microsporon Andouini, an affection which is quite frequent, and which we should designate by the name of the two authors who were the only ones to give a good description of the parasite, with an interval of fifty years between Drs. Gruby and Sabouraud.

It is the old tinea tonsurans vulgaris, whose parasite is constituted by very small multiple spores. It is the variety to which Sabouraud had given the name trichophyton microsporon before having recognized that it was in reality the parasite formerly described by Gruby under the name of microsporon Andouini.

This tinea is the most tenacious of all and the most obstinate in the presence of medication known till the present time.

2d. Trichophytic tinea of human origin, in which the parasite is constituted by large spores, all contained within the hair and disposed in regular chains along its longitudinal axis. This is the trichophyton megalosporon endothrix of Dr. Sabouraud.

3d. The trichophytic tineas of animal origin, which are very rare, since they are about only one-twentieth of the cases.

They are due to numerous species. The parasites are characterized by spores of variable size and affect the hair in the root portion.

These are the trichophytos megalosporon ectothrix of Dr. Sabouraud. These last varieties are ordinarily much more readily cured than the other two.

Dr. Martin, in his inaugural thesis, written in great part under the inspiration of Dr. Sabouraud, has made a study of the treatment of these different varieties. He proposes to begin by making an application of tincture of iodine over the whole scalp; in this way one can map out with the greatest precision all the affected points, however small they may be, by the staining, which is much darker than that of the surrounding healthy skin.

Aside from this, as we have already long ago said, these iodine applications at the beginning of the disease, while it has not yet had time to plant itself deeply, constitute an excellent means of treatment.

We can thus at times circumscribe the disease, prevent extension, and then, after some days of this medication, the lesions which persist should be seriously attacked. It is understood that in all *tinea tonsurans* the hair should be kept cut close, by means of curved scissors, over the whole surface of the head, the diseased plaques encircled by an epilated border six to ten millimeters wide, the head washed with some antiseptic soap and kept constantly covered with a linen cap, to be changed every day and carefully disinfected.

All of these precautions and this operative procedure are at the present time universally adopted in France.

The following is what Dr. Sabouraud has newly introduced into this plan of medication: In the *trichophytoses* of animal origin we are often obliged to begin with a calming treatment, for they are frequently accompanied by folliculitis and suppurative processes. We, therefore, apply either cold meal poultices or dressings of aseptic boric gauze. If there is no inflammation we apply, on the contrary, vaseline containing iodine, in gradually increasing strength, from 1 up to 20 per cent., and even go so far as to make applications of tincture of iodine and dressings of Vigo plaster, or the red plaster of Dr. Vidal (minium 2.50, cinnabar 1.50, dia-chylon 26).

In the *tinea tonsurans* having large spores and of animal origin Drs. Martin and Sabouraud recommend, after washing and peripheral epilation, that every day or every second day, according to the irritation of the plaques, an application of tincture of iodine be made, and over this a layer of Vigo plaster. It appears that the results are better when the same piece of plaster is reapplied until it can no longer be used.

In cases where the points of attack are extremely numerous, small and scattered over the whole scalp, Dr. Sabouraud has employed with success iodized cotton, applied over the whole scalp in thick layers and renewed every second day.

In the *tinea tonsurans* having little spores (the Gruby-Sabouraud disease) Dr. Sabouraud has for some time employed an ointment containing carbonate of potash (pure), 5 to 10 grams; distilled water and oil of sweet almonds, each 5 grams; vaseline, 40 grams. This is applied in alternation, with tincture of iodine, in the following manner: The ointment is left on for twenty-four hours; the head is then washed with soap and plenty of water, and the iodine then applied. As soon as the layer of iodine is dry the ointment is reapplied for twenty-four hours, and so forth. In this way the diseased areas are cured with relative ease.

At the present moment Dr. Sabouraud prefers the following procedure, of which he has given me the formula, which I copy literally: 1st. Each

night the diseased plaque is entirely covered with a tampon of absorbent cotton, wet in the following solution: Chloride of lime, 15 grams; water, 300 grams (shake before using and dilute one-half with water); cover with a piece of caoutchouc to keep the dressing in place. 2d. The following day wash with soap and cover with a piece of diachylon plaster. 3d. Twice a week apply tincture of iodine to all the plaques.

In the final stages of the tineas, when there are only a few hairs left in each plaque, which seem to resist all ordinary procedures, Dr. Sabouraud thinks we are authorized in destroying them directly, either with the croton-oil pencil or by electrolysis. These views are equally entertained by Dr. Wickham.

**Abortive Treatment of Furuncle by the Actual Caution.**—Dr. Loewenberg, whose interesting work in the field of microbiology relating to furuncle is well known, has just published an article in the *Bulletin Médical* recommending actual cautery in the abortive treatment of boil. For this purpose he employs galvano-cautery irons, ending in fine platinum points, about a centimeter long and a millimeter in diameter, as soon as a furuncle shows its presence by a red area surrounding a hair and by the special sensitiveness to the touch so well known to all who have suffered from boils. He introduces the platinum point, brought to a white heat, into the center of the areola, causing it to penetrate deeply enough to act upon the whole length of the hair follicle in the supposed course of which it is made to enter. The incandescent point is left for an instant in position and then withdrawn.

When the furuncle has already begun to form we may still attempt to abort it, but we must, in this case, prolong the cautery so as to completely carbonize the small drop of pus which has already been produced.

[Without wishing to diminish in any particular the merit of Dr. Loewenberg, I will be permitted to remark that for a long time dermatologists in France have had recourse to the actual cautery, applied by means of finely pointed thermo-cautery tips, or, better still, with the electro-cautery, to overcome rebellious acnes and those with large lesions upon the face and trunk. We have, indeed, remarked that we not only succeed in curing, in this way, more rapidly the lesions operated upon, but that we obtain, by this method, a quite prompt cessation of new lesions. It would seem that we thus destroy the inoculable germs which produce acne. Dr. Loewenberg's method is not absolutely his own, but he has applied it especially to furuncle and to furuncle of the ear more particularly.]

**Treatment of Folliculitis of the Vestibule of the Nasal Fossæ.**—Dr. Courtarde made a communication to the Therapeutical Society of Paris, on May 9, 1894, upon the treatment of folliculitis of the vestibule of the nasal fossæ, an affection to which he wrongly gives the name sycosis. When the disease is limited to a few follicles he opens the pustules, removes the hairs which pierce them and which are but slightly adherent, and then applies, on a tampon of absorbent cotton, camphorated salol solution. This is renewed several times a day, especially if the patient has abundant mucopurulent nasal secretions. When the crusts are thick and adherent he softens them with frequent lotions of hot boric acid solution, and then detaches them with care, so as not to provoke new inoculations. When the



vestibule is cleansed he dresses with absorbent cotton, wet with the camphorated salol, making enough pressure to insure penetration of the solution to the *culs de sac* depressions and fissures caused by the disease.

According to the author the camphorated salol forms a sort of antiseptic protective varnish, which prevents the propagation of the inflammation to the neighboring follicles and permits the diseased follicles to cicatrize rapidly. He has been able to cure by this process, in a few days, cases of folliculitis of the vestibule which had existed for months.

[We have had no personal experience with camphorated salol and, consequently, must abstain from judgment of Dr. Courtarde's method; but we desire to put practitioners on guard against the use of salol and powders containing it in affections of the mucous membranes of the nasal cavities. We have had occasion to treat several patients who, after inhalations containing this substance, have been seized with an intense erythematovesicular eruption, accompanied by enormous swelling of the mucous membrane and adjoining portions of the face, the whole closely resembling an attack of phlyctenular erysipelas. Unless we are sure of the freedom from idiosyncrasy—and we know how much these predispositions vary in different individuals and, indeed, in the same subject, according to circumstances which are not yet well understood—I do not think it prudent to prescribe powders containing salol in affections of the nasal fossæ.]

**Treatment of Epithelial Cancer of the Skin by Methyl Blue.**—Dr. Darier has again just taken up the question of treatment of epitheliomas by methyl blue. Everyone knows the quasi elective action of this substance upon epithelial tissue. The author begins by freeing the ulcerative surfaces of crusts by aseptic sprays or poultices. If there exist on the borders thickened resistant elevations they are touched with the galvano-cautery, so as to permit the chemical agents to penetrate to the deeper layers. The cleansed surfaces are then covered with cotton wet in a 10 per cent. solution of cocaine, and are then painted with a concentrated solution of methyl blue (1 gram of methyl blue to 5 of alcohol and 5 of glycerine).

All the parts colored blue are now lightly touched with a steel stylet moistened in a 5 per cent. solution of chromic acid. A reaction, producing a purple color, takes place. The blue is applied for a second time, after which the surrounding parts are carefully washed to remove any excess of staining. As a dressing, either potato-powder poultices or compresses, wet in a weak solution of corrosive sublimate, are applied to prevent the formation of crusts.

This operation is repeated every second day for four or five times, and then the methyl blue alone is used. This treatment lasts from three weeks to two months in superficial epitheliomas, according to their extent. In deep forms the author has had good results from interstitial injections of methyl blue. They bring about a softening in the center of the tumor. The contents of the pocket thus formed are evacuated, and he then acts upon the walls of the cavity with methyl blue and chromic acid.

[We have also experimented with methyl violet, but are much less enthusiastic than Dr. Darier. In employing it by itself, as it is logical to do, in order to appreciate its exact value, we have usually obtained only very imperfect results, and those open to question. We believe, however, that one is authorized in saying that the method can be employed when the pa-

tients will not hear of operation of a radical nature—raclage, destruction by the red iron, or energetic caustics.]

**Acarophobes.**—Dr. Thibierge, in a recent clinical lecture, has called attention again to a series of patients—much more numerous than is usually believed—who imagine themselves to be infected by such parasites as the *acarus*, *pediculi*, etc., when no such trouble exists. These are almost always neuropaths, neurosthenics, or hysterics. Some have already had the itch, and believe that they have not been cured or that the affection has recurred, while others believe themselves the victims, when they have never had the disease. Those affected are usually subjects of rebellious pruriginous dermatoses, and at times of well-defined dermatoses, such as eczema, chronic urticaria and occasionally purely nervous affections of the type of pruritis senilis. It is often very difficult to convince these patients that they are not suffering from itch, and they will not listen to the physician. One is occasionally obliged, in order to demonstrate their error, to put them through a complete course of scabies, which fails to give relief. Those having the cocaine habit are frequently acarophobes; they feel, indeed, peculiar sensations in the skin which lead them to bore into their skin with a needle or point of a knife, in order to extract the animalcules.

[These hallucinations concerning the skin are relatively frequent in neuropaths, and, for my part, I have observed several cases. One of the most complete examples I have encountered was furnished me by a woman of sixty, who followed me up for over six months, at my polyclinic of La Rochefoucauld, entreating me to rid her of the little beasts she had in the skin, and which she said were gnawing at her. The hallucinations went so far that she claimed she could see them at times come out upon the surface. It is useless to add that she was never able to show one of these animalcules. The skin was entirely free and did not even show any signs of scratching. I was unable to convince this patient of her error, and was never able to free her from the sensations, either by hydrotherapy, sedative lotions or by antipruritic ointments. These patients are evidently candidates for the lunatic asylum, if not already demented.]

**Grattage and Immediate Reunion in Ulcerating Bubo.**—Dr. Mermet, a pupil of Dr. Balzer, has just published in the *Archives Générales de Médecine* an interesting work upon the treatment of buboes. He has noted that the two best methods of treatment till now have been scraping and immediate reunion, and he has had the idea come to him of combining the two, so as to make a sort of mixed method. This procedure can, evidently, not be applied to the ordinary chancroidal bubo, because the scraping would simply cause inoculation of the denuded parts; therefore it is intended only for the inflammatory buboes, of whatever origin (gonorrhœal, chancroidal, syphilitic). It is especially indicated in the large glandular ulcers with ill-conditioned base, covered with irregular fleshy masses, giving rise to an interminable suppuration. To operate, we first render the parts insensitive with cocaine, or with chloride of ethyl or methyl. The whole region is then rendered antiseptic. Fistulous tracts are slit up with the bistouri on a grooved director. With a Volkmann curette all the fleshy masses are removed, as are the ill-disposed tissues at the base of the glandular cavity. It is necessary to act energetically and reach sound tissue. The lips of the ulcer are then abraded with scissors or the knife, so as to transform the

wound into two bleeding surfaces, which will grow fast to each other. The glandular cavity is finally touched up with a 20 per cent. carbolic acid solution, or a 10 per cent. solution of chloride of zinc, after which suturing is proceeded with, the attempt being made to make the stitches as deep as possible. Iodoform gauze is used as a dressing; a little compression is exerted and complete rest in bed enjoined, with the limb kept in a position of extension for the few following days. About the fifth or sixth day the sutures are removed. Thus is almost always obtained an immediate reunion in about eight days, followed by a linear cicatrix of regular form.

PARIS, June 30, 1894.

L. BROCC.

#### POLYNEURITIS SYPHILITICA; INVOLVEMENT OF THE PNEUMOGASTRIC NERVES.

*Dear Sir*—The following history may interest your readers, as it presents, I think, a typical instance of syphilitic multiple neuritis which terminated fatally within six months from the date of the appearance of the initial lesion, in otherwise a mild form of the disease.

Widower, æt. 48, of a neurotic temperament, very impressionable, anæmic, thin, not strong but of good habits, and not addicted to the use of alcohol or tobacco. Since the death of his wife in 1887, has been continent, but at last yielded to the suggestions of his carnal nature, not without knowing, as he thought, all about the women with whom he cohabited, and he still repudiates all suspicion. Nevertheless, he now (March 31, 1893) presents himself with a superficial ulceration situated just within the meatus extending very nearly the entire circumference of the urethra, with a split-pea induration, the lymphatic vessels on the dorsum extending from the glans to the root of the penis are very much distended, indurated and sensitive to pressure. The lymphangitis preceded the adenitis a few days, but soon both inguinal, epitrochlear and post-auricular glands, especially on left side, became distinctly enlarged. May 13th, comes with a disseminated papulo-squamous and pustular eruption, with fleeting pains in his extremities. Elevation of temperature particularly at night, with insomnia. He was put on three tablets of Hyd. Protiod., gr. one-fifth, three times a day. From this on nothing noteworthy transpired, excepting the variation of the dose of mercury. He much reduced the dose at times, because he thought it irritated his alimentary canal. August 28th—nothing now remains but the copper-colored stains of his eruption. He complains of pain in the dorsal regions of his back, which he attributed to muscular rheumatism, due to a sudden suppression of perspiration. The pain was located in the region of the fourth or fifth dorsal vertebra and was generally of a dull, persistent character, but at times, notably at night, grew so intense that he sought relief in hypodermics of morphia. In the course of three or four days there occurred an almost simultaneous impairment of sensory and motor impulses of the extremities. First, he complained of numbness of fingers of both hands, with muscular weakness of flexors, perceptible to grasp of hands, especially of right, and afterward a similar numbness with loss of power in both legs. Although he was in bed but two days he could not walk a few feet from the bed without assistance. There was an entire absence of the patellar reflexes on both sides; marked restlessness, insomnia, some headache and slight diplopia. His pulse, respiration and temperature were about normal. I

last saw him September 3d, when I advised his removal to St. Luke's Hospital, where he could receive better nursing than at the hotel where he was lodging.

On his admission to that institution the diagnosis was again made by the attendant of multiple neuritis, but either because the patient did not give syphilis as a possible etiological factor or some other reason, the specific treatment which had been kept up until then was suspended, and he was given sod. salicylici, strychnine, morphine, ammon. carb. digitaline, oxygen, etc., to meet the contingent symptoms as they arose. But, notwithstanding his symptoms increased in severity, records of the hospital show that his limbs became painful and sensitive to the touch in some parts; restlessness increased with hallucinations; very noisy. September 12—patient complained of choking sensations as if sputa had accumulated, and unable to be expectorated. This continued more or less until the time of his death, which occurred on the evening of September 15th.

Respiration on September 13th was 24 and continued to rise in frequency until the 15th, when it was 44. Pulse on the 8th was 108, then continued to increase until the 14th, when it was 153. Temperature did not reach 100 until the 14th and was only 101.04 at the time of his death; no autopsy could be obtained. The bilateralism of the anesthesia, separated by an area in which there remained normal sensitiveness, makes it more than probable that the patient suffered from a toxic polyneuritis rather than a disorder of the central nervous system. The difficulty in expectoration, the frequent and shallow respiratory movements, and the rapid and irregular action of the heart, with an almost uniformly normal temperature, pointed to an impairment in the function of the pneumogastric nerves on which the lethal termination depended.

Yours truly,

ALEX. W. STEIN.

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## Book Reviews.

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*Diseases of the Skin. An Outline of the Principles and Practice of Dermatology.* By MALCOLM MORRIS, Surgeon to the Skin Department of St. Mary's Hospital, London, etc., etc. With 8 Chromo-Lithographs and 17 Woodcuts. Philadelphia. Lea Brothers & Co. 1894.

DR. MORRIS occupies a distinguished position among the group of British dermatologists, and is well known in this country by his contributions to the literature of the subject. His extensive clinical experience and his ability as a writer have well fitted him for the task of preparing a work on Diseases of the Skin. This work is not to be classed with the numerous manuals of dermatology which have appeared within recent years; it is much more comprehensive in its scope, and aims to present the clinical facts and principles of treatment of skin diseases in a thorough and complete manner. For extended details of morbid anatomy the reader is referred to the standard text-books.

The distinguishing peculiarity of Dr. Morris's book is the attempt to group diseases of the skin upon an etiological basis. Laying down the general proposition that the three chief factors in the production of skin diseases are, (1) individual proclivity, hereditary or acquired; (2) nervous



derangements; and (3) parasitism, the author follows in this arrangement mainly the lines already traced by Unna.

Under "Affections of the Skin Dependent on Nerve Disorders" are included not only the generally recognized neuroses and angio-neuroses, but also a large number of diseases commonly classed by other writers as inflammations of the skin. In this group he places such dissimilar affections as lupus erythematosus, pemphigus, lichen ruber planus, etc. A large and composite group is made up of affections which are the result of the action of parasites, and which are classed as "Local Inoculable Diseases" and "General Inoculable Diseases." Many of the diseases which are clinically most important, as eczema, psoriasis, pityriasis rubra, etc., and new growths are unclassified.

While we recognize that an etiological classification of skin diseases represents the ideal system, it must be admitted that in the present state of our knowledge such a scheme is impracticable. Numerous objections to Dr. Morris's classification might be pointed out, the author's conception of the etiology of certain diseases being presumptive merely, and not based upon positive knowledge.

As regards the general character of the work we can only speak in terms of commendation. The description of the symptoms, diagnosis and treatment is clear, concise and eminently practical. Few works on dermatology contain so many essential details condensed in so little space.

The illustrations are for the most part quite good. The flesh-tints of the chromo-lithographs are perhaps too pronounced in color, but are admirably arranged for the purpose of differential diagnosis.

*Traité Descriptif des Maladies de la Peau. Symptomatologie et Anatomie Pathologique. (Descriptive Treatise of the Diseases of the Skin. Symptomatology and Pathological Anatomy.)* LELOIR and VIDAL. G. Masson, Paris, 1893. Part V.

The death of Dr. Vidal is bringing this valuable work to a sudden close, leaving it in a most regrettable state of incompleteness. The text of the Treatise ceases abruptly with this part, terminating with the discussion of favus which was begun in Part IV., the last published before Vidal's death. The publication of the plates will be continued according to the author's announcement, in two divisions, still to appear. The number of these will be fifty-four, as originally intended, but, in consideration of the discontinuance of the text, the price will be reduced for the entire series from 90 to 70 francs.

Vidal, it seems, had entire charge of the clinical portion of the work; Leloir of the anatomical. The latter thinks the time which would elapse before he would be able to complete the text would be necessarily so long that the treatise would lose much of its homogeneity and usefulness, so, under the advice of his friends, the publisher and Mme. Vidal, the work will be continued only as an atlas.

In the text, Vidal takes up favus of the nails and Kaposi's case of favus of the stomach and intestines. His consideration is then turned to the achlorion, its microscopical and macroscopical characteristics and the culture methods applicable to it, with a review of all the best work on the subject. The tube cultures are illustrated by three cuts taken from Pick

and Kräl. After a short résumé, the article terminates with a brief notice of the work done on favus in the lower animals.

The colored plates in this issue are almost exclusively occupied with lupus vulgaris, vegetans et papillomatosus, complicated with epithelioma, lupus scléreux, erythematosus, erythemato-acneiformis, and elephantiasis. The stain employed and illustrated in the colors, is, as before, always the picrocarminate of ammonia. Its constant use is probably explained by the fine results obtained. Even the delicate reticulated connective tissue whose existence in the lupus erythematosus was denied, is clearly and beautifully shown. These plates are peculiarly interesting in view of the theory that the process here begins in the cutaneous glands. The infiltration is localized in the neighborhood of the sebaceous and sudoriparus structures and the blood-vessels. A second plate shows the embryonic cells undergoing granulo-fatty or colloid degeneration with younger bodies invading the dermic connective tissue and altered portions of the integument. In the derma, after degeneration, all signs of the infiltration are seen to be absorbed and to disappear. The microscopical anatomy of elephantiasis nostras is shown in the skin, subcutaneous tissue and the sciatic nerve. Besides these two disorders, there are plates illustrative of tinea versicolor, an intestinal villus in purpura, molluscum fibrosum and a really beautiful section of a dysidrosis phlyctenule. Of the mechanical work of the plates themselves nothing more need be said; they are as nearly perfect as French art can make them.

J. C. J.

*Practical Lectures in Dermatology.*—CONDICT W. CUTLER, M.D. G. P. Putnam's Sons, New York, 1894.

There seems, at first sight, no excuse for the continued multiplication of hand-books, so-called, on the subject of diseases of the skin, except the apparently vain hope that one may at last be published which will give "the student and the general practitioner" some idea as to their diagnosis and treatment. It is a pity that the author, in his preface, had not offered this instead of the threadbare apology which there appears, for his work is worth the reading, not only to the class to which he appeals but to dermatologists who have the benefit of long experience. It is not that the matter is either new or startling, or that the treatment shows brilliant departure from well-established lines, but that the volume is a clear, concise epitome of our knowledge regarding the more common of the long list of cutaneous diseases.

The book is a compilation of fifteen lectures delivered by the author to the students of the University of Vermont. Such being the case, the list is necessarily incomplete. Fifty-one diseases are considered, and the consideration of each affection "the soul of wit," for brevity. While brief, it should be remarked that no salient point is omitted, and therein lies the usefulness of the work. No one can expect a comprehensive treatise on such a subject as eczema in fourteen small pages; but the hints are valuable and will serve very well for sign-posts along the high road to a more complete mastery of dermatology. We would particularly commend the treatment—the chapter on General Therapeutics is admirable—as being carefully written and quite up to the latest advances in this line. There are only two exceptions to be taken to it: one, the author's enthusiasm for the results of his chloral, iodine and carbolic acid mixture, which is shared by few, and the other, number

of formulæ given in full, always a poor service to a beginner. Differential diagnosis receives only passing mention, the reader being referred to Cutler's "Differential Diagnosis" for the points needed. Symptomatology, pathology and etiology have fuller consideration.

The volume deserves the praise bestowed upon it; but on careful reading certain doubtful points and discrepancies appear here and there. The points of dispute may, however, resolve themselves into mere differences of opinion. For example, on page 11 the author states that in psoriasis itching is constant; on page 159, that it is "usually well pronounced." The statements should at least be reconciled in the next edition. Ecthyma is generally no longer classed a distinct disease, but a clinical condition, easily recognized and due to a number of causes resulting in the infection of the skin with pus cocci. On page 104, anthrax appears in parenthesis after carbuncle, instead of malignant pustule. On page 120, impetigo contagiosa is stated to be "confined almost exclusively to children who are uncared-for and uncleanly;" on page 129, lichen planus, according to the author, must be differentiated from papulo-squamous eczema and syphilides (the italics are ours). The papules of this disease are not described as scaly.

The book needs the offices of a good proof reader, for misprints constantly strike the eye, and while they may do no harm, they certainly detract from the general excellence. We are fortunately spared the efforts at illustration which usually mar these hand-books.

J. C. J.

*Transactions of the American Dermatological Association.*—GEORGE JACKSON, Secretary. New York, 1894.

This official report of the proceedings of the Association at its Seventeenth Annual Meeting, in Milwaukee, is uniform in size and general typographical appearance with the publication of the previous year. As in the latter case, it consists almost exclusively of reprints from this JOURNAL, with the additional advantage, however, of having the discussion of each paper immediately following it. The several contributions by the members and by Dr. Crocker, of London, having already appeared, and being familiar to the readers, nothing remains to be said regarding them. The two colored plates which accompanied Jackson's and Crocker's papers are reproduced, as well as the micro-photographs in Fordyce's "Contribution to the Pathology of Acne Varioliformis," which, it should be remarked, appear to have lost something in definition in their transition. Again, we congratulate the Secretary on the gratifying result of his labors.

J. C. J.

*Cheratomye Simmetrica Palmare e Plantare da Trofoneurosi.* By DR. A. GILETTI. Turin, 1894.

This is a pamphlet of six pages of wide-margined letterpress. Two full-page admirable chromo-lithographs, and one full-page blue print. The author reports one case with the above name that resembles Kaposi's, "Keratosi verrucosæ palmæ manus et plantæ pedis." It differs from it mainly in subjective symptoms, but the two diseases clinically bear a very close resemblance. We wish that it were possible to produce such elegant monographs in this country at an expense moderate enough for most physicians to meet.

G. T. J.

## Selections.

### THYROID NOTES.

#### Glycosuria from Ingestion of Thyroid Extract.

W. DALE JAMES (*Brit. Journ. of Derm.*, June, 1894), gives notes of a case, the patient a man of 45 and "an old psoriatic." Following the taking of four tabloids of the extract daily, nervous symptoms, depression, palpitation, flushings began to appear. After two weeks he complained of polydipsia; his urine was much increased in quantity and acetone could be detected in his breath by its odor. The sp. gr. of his urine was 1032 and sugar was found at every test. He was placed on diabetic diet and the thyroid administration stopped. In less than a month the sugar disappeared and in six weeks the patient was entirely restored to health except for his psoriasis, which was not in any way improved by the treatment.

#### Lupus Treated by Thyroid Extract.

BYRON BRAMWELL (*British Medical Journal*, April 14, 1894,) reports the results of this treatment in two cases. In the first, a girl aged 16½, whose disease had persisted for nine years, covering the nose, left cheek and upper lip, and extending from each corner of the mouth to the chin, administration of the extract was continued, with a few intervals, from February 13th to July 28th. At the latter date the improvement was marked. In an intermission the disease retrograded, but improved again on the resumption of the thyroid treatment. After a year the patient was much improved, not cured. The second was a girl of 18, whose nose, mouth and right eyelid were affected. Noticeable improvement was made within a month. The disease in its various stages is shown in accompanying photographs.

#### Thyroid Extract in the Treatment of Syphilitic Psoriasis.

JOHN GORDON (*British Medical Journal*, January 27, 1894.) describes a case which he denominates under this head, and which is probably a papulo-squamous syphilide, occurring over the whole surface of the body, including the palms and soles. After five weeks' treatment by mercury and arsenic there was considerable improvement, but this line was stopped and the patient placed on thyroid. In three weeks the disease had disappeared, leaving only the usual pigmentation, but, as the author takes occasion to remark, doubt remains as to whether the gland extract exercises any controlling influence over the cutaneous manifestations of syphilis.

JOHNSTON.

#### Dermatitis Exfoliativa Pigmentosa. HENRY HANDFORD. (*Brit. Journ. of Derm.*, Vol. VI., No. 3, 1894.)

The disease bore a close resemblance to the pityriasis rubra of Devergie, with the exception of the pigmentation, which was very intense. Arsenical pigmentation is not usually so intense or so widely diffused, and argyria was excluded by the freedom of the mucous membranes from disease and absence of a history of the ingestion of silver salts.



The patient, a man of 55, on being stripped, showed a skin over the whole surface of the body as dark as a mulatto. He had no symptoms of Addison's disease. The cutaneous surface was found indurated, rough and scaly. The scaling was so abundant that a double handful could be collected from his bed daily. An occasional bulla (noticed in Devergie's descriptions) formed during the progress of the disease, determined generally by exertion and sweating. The trouble began thirteen years ago, but during the Summer of 1893 its spread was most rapid. The pigmentation began about May, the face being as dark as the rest of the body. The skin of the trunk was much reddened, but on the limbs its thickening was too great to permit any hyperæmia to be noticed.

He was improved by quinine, warm baths and Unna's liquid gelatine painted over the skin and fixed by bandages. After two months the skin became less infiltrated and moist, desquamation ceased, but the pigmentation was unchanged. The disease displays a tendency to recurrence when the patient's work as a collier is resumed.

JOHNSTON.

**On the Nature of Urticaria.** STEPHEN MACKENZIE. (*Brit. Journ. of Derm.*, Vol. VI., No. 3, 1894.)

The physiology of the urticarial lesion forms the opening consideration of the paper. The development of a wheal is a process determined by a reflex mechanism set in motion by two sets of stimuli. Here, as elsewhere, the mechanism must consist of afferent nerves, a center and afferent nerves, the center being located in the plexus of fine fibers ramified through the superficial layers of the corium. The stimuli which awaken the activity of this system are direct or indirect; they are external irritants applied directly to the surface of the skin, *e. g.*, changes of temperature, nettles, or they arise from the ingestion of certain substances endowed with toxic properties. In the latter case some poisonous product of faulty digestion is absorbed into the blood and irritates, by its chemical action, the superficial plexus. The ultimate cause is then, in the writer's opinion, the same in both cases, stimulation of this center; and the fact of the general distribution of urticaria is, he thinks, an evidence of the correctness of the theory.

Referring to the occurrence of urticarial wheals on the mucous membranes of the mouth, air passages (its alternation with the phenomena of asthma) and stomach, the more unfamiliar causes of the affection are next taken up. The first is the connection of the disease with the presence of hydatids. Urticaria has been produced (Debove, *Lancet*, Vol. 1, 1888, p. 34.) by the injection of hydatid fluid under the skin, and the author gives a case in which an outbreak followed the rupture of a cyst in the abdomen. It may occur independently of any poison, following parturition, the passage of a uterine sound, or being coincident with menstruation and pregnancy.

(The writer does not appear to regard this as invalidating, in any way, his theory that the disease is due to irritation of nerve plexuses of the skin itself. He says it occurs, here, "by a reflex mechanism.")

The next consideration is that of unusual cases of urticaria, which are given in full: A case of urticaria hemorrhagica, in which the wheals resembled large bruises; a chronic case, following varicella, of thirteen months' duration, with no discoverable cause. A predisposition probably existed in

this instance, since the patient's sister suffered from the same trouble for twelve years. A case of urticaria pigmentosa in a boy of 14, in whom the first lesions were noticed a few days after birth and persisted almost continuously for eight years, follows. The disappearance of the wheals left large, brown, pigmented spots on the skin of the trunk and upper extremities. The next case is one of the giant form of the disease. The patient, a laborer, presented himself with his arms and face greatly swollen. His mouth and throat were affected. As it went on to recovery the disease appeared in quick succession in other parts of the body.

Treatment should be directed toward removing the causes of the trouble and toward mitigating its effects. External irritants are to be removed and the patient clothed in soft and soothing garments next the skin. Noxious matters must be removed from the alimentary canal in acute cases, the diet watched and restricted in the chronic. Local measures include warm baths, with starch or potassium sulphuret, and frictions with carbolic acid and glycerine, or ointments of various antipruritics. Of internal remedies antipyrin is the best; twenty or thirty grains may be given at night. Atropine (gr. 1-120 to 1-100 gr.) is sometimes beneficial. Charteris recommends salicylates; Anderson, bromides. Pilocarpin gave fair results in the case of urticaria pigmentosa narrated.

JOHNSTON.

**The Course of Syphilis as Influenced by the Early Internal Treatment with Mercury.**—L. JULLIEN (*Monatshefte für prakt. Dermatologie*. Band XVIII., heft 9).

The well-known French author has studied this question for the last twenty years, and from the examination of several hundred cases has come to the conclusion that a quick saturation with mercury prevents considerably an early occurrence of tertiary symptoms. Those examinations were made at a time when the strong insoluble Hg. preparations were not yet generally used. Jullien did not consider it impossible that by the more energetic and persevering treatment with mercury we would be enabled to prevent all future symptoms or to mitigate them to such a degree that the amelioration practically amounted to a cure.

The mode of treatment he considers the best is the intramuscular injections with calomel, suspended in liquid vaselin (1:10). Properly executed there is no danger of intoxication and no salivation provided that the kidneys act well, and that the gums are in good condition. There is no danger of phlegmons if the injections are made in the houses of the patients, and if the latter are kept quiet for one or two days. Part of the salt is kept *in loco injectionis* as a reservoir; the saturation of the body with calomel can be recognized by gingivitis, sense of tightness of the chest and a tendency to syncope. The calomel injections are practiced immediately after the syphilom has been diagnosticated, in intervals of two weeks for a period of two months. The usual dose is 10 cgm. After the first and up to the sixth month the injections are made every twenty to thirty days.

These are the general rules; the author, however, individualizes as to time and quantity. Under this treatment the secondary symptoms, if they appear at all, consist in "somewhat duller aspect" of the mucous membrane of the tonsils and of the soft palate, and superficial erosions, which the author is inclined to consider accidental. In one case he saw one single papule after sixty-seven days, in twenty cases maculæ after one hundred

and thirty-eight days. If a very early treatment was instituted and continued sufficiently long, the skin remained totally intact. In three cases a nearly absolute immunity for three and a half years was observed, which the author considers a guarantee of safety for the future.

The paper is said to be based upon a thorough study of thirty cases upon whom the author's principles of treatment have been practiced with varying success.

GOLDENBERG.

**Treatment of Syphilis with Injections of Calomel and Hydrarg. Salicyl.**—K. E. LINDEN (*Archiv. für Dermatol. und Syph.* Band XXVII., heft 2).

The material which was used for Linden's examinations were soldiers of good constitution, of about the same age and observed under the same circumstances.

Calomel injections were made two hundred and eighty-six times in forty-three patients, in only twenty-one per cent. of the cases without local reaction. Most of the injections were very irritating, and were followed by painful infiltrations and in a considerable number by abscesses.

Of nine hundred and thirty-five injections with hg. salicyl. in paraffin liquid no abscess was observed. Infiltrations which occasionally occurred did not give rise to great inconvenience. Stomatitis and fever with general malaise was observed in a small number of cases after the first injection, to disappear on the second or third day.

The author concludes that the calomel injections are more powerful for the time than those with hg. salicyl. The latter, however, produce less local irritation, and seem to shorten the course of the disease more than the former.

GOLDENBERG.

**The Frequency of Posterior Urethritis and the Time of its Observation in Acute Gonorrhœa.**—A. LANZ (*Archiv. für Dermat. u. Syph.* Band XXVII., heft 2).

Lanz concludes from an examination of ninety-two patients with primary infection :

1. Urethritis posterior is observed in eighty per cent.
2. It is no complication of gonorrhœa, but a certain stage of development of the latter.
3. It is not accidental, and not absolutely produced by external causes (excess in baccho et venere) or by predispositions or constitutional diseases. The external causes, however, favor the early development of urethritis posterior.

4. The occurrence is independent of the treatment which is employed in acute gonorrhœa. Urethritis posterior is observed whether internal treatment has been used or injections resorted to.

5. Urethritis posterior develops in twenty per cent. of the cases in the course of the first week, in thirty per cent. in the course of the second week, therefore in one-half of all cases in the course of the first two weeks.

6. In some cases of urethritis posterior no subjective symptoms are noted. The diagnosis in these cases can only be made by a repeated examination of the patient's urine.

GOLDENBERG.

**Pruritus Vulvæ.**—DR. A. CZEMPIN (*Dermatolog. Zeitschrift.* Heft 4).

Pruritus vulvæ is mainly localized on the clitoris, labia minora, inner

side of vulva and introitus vaginæ. The changes which the itching and the consequent scratching produce are characteristic of the affection, viz., mucous membrane is dry and of a gray, whitish color, as if powder was dusted on. Cervicitis or endometritis is often combined with pruritus vulvæ, but there is no etiological connection between them.

As to the treatment of the affection, which the author is more inclined to consider of neurotic and constitutional origin than of parasitic nature, he lays the main stress on general treatment, interdicts nitrogenous food and recommends sedative remedies and diet. As last resort he gives solutio Fowler, which has proved to be very efficacious in his cases. He advises the avoidance of examinations and local gynæcological treatment.

GOLDENBERG.

### The Present Position of the Question of Vegetable Hair Fungi.

DR. LESLIE ROBERTS, of Liverpool, in his paper read before the Dermatological Section at the Annual Meeting of the British Medical Association, held at Bristol, 1894, said that considering the amount of research which had been given to the vegetable hair parasites since the time of Gruby it was surprising how little progress had been made in the direction of real knowledge. The cause of this backwardness, in his opinion, was the want of a sense of the relative importance of the different methods of research. The writer described three methods of research—namely, 1, the histological; 2, the phytocultural; 3, the physiological. The histological was the examination of the fungus in situ in its natural position in the hair or scale: the phytocultural was experimentation by culture. The author entered at some length into a critical examination of this method as to its limits and possible usefulness. He afforded experimental proof that this method could not be relied upon for determining the question of species in regard to the vegetable hair fungi. To apply it to this purpose was an abuse of the principles and practice of botany. The question of species was of no importance to medical men unless it involved the question of origin and other practical points connected with the natural history of fungi. To enable us to observe the parasitic fungi at their own work he had introduced a method of research which he called the physiological method. His plan was the reverse of that usually followed. Instead of carrying the parasitic plant to the animal and inoculating it, he brought the desired part of the animal, namely, the hair, to the parasite. The writer then entered upon the details of this method, which were demonstrated to the section in actual operation. It was thus possible to study the growth of the trichophytons in vegetable soil and their transference to animal tissue, or hair, without any change in the saphrophytic habit of the plants. The hairs when thus invaded appeared in all respects like naturally diseased hairs. The writer claimed that these experimental observations showed the weakness of M. Sabouraud's triple method of establishing species. They demonstrated that characters which M. Sabouraud had described as "absolute" and "constant" were, on the contrary, relative and changeable. The "ectothrix," or external vegetation was not a certain sign of direct animal origin. The "endothrix" and "ectothrix" character of vegetation might change as the fungus passed from one host to another; on one host there might be only internal vegetation, and on another external and internal.

The physiological method pointed to the saphrophytic origin of the



trichophytons. There could be no doubt, in his opinion, that all trichophytons were really of the nature of saphrophytes. Dead organic matter was their original source. The fungi ascended to their position on man through the chain of domesticated animals which come habitually into closer contact with saphrophytically decomposing matter than man himself. Animals in a state of nature were, so far as he knew, at present exempt from attacks from these fungi. It had yet to be proved whether their exemption was due to some peculiarity in the hair or to the fact that they did not come within the circle of man's domesticated habits.

The writer concluded his paper with reference to the influence which soil exerted in the production of microscopic variations in the several trichophytic fungi.

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### Books and Journals Received.

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- Hypertrophies and Degenerations of Cicatrices and Cicatricial Tissue, by John Collins Warren, M.D. (Reprinted from *Annals of Surgery*, September, 1893.)
- Neurotic Eczema, by C. R. Barham, M.D. (Reprinted from *The Medical News*, March 25, 1893.)
- External Urethrotomy, by B. M. Ricketts, M.D. (Reprinted from *The Medical Record*, June 24, 1893.)
- The Cure of Complete Prolapse of the Rectum by Posterior Proctectomy, by John B. Roberts, M.D. (Reprinted from *The American Journal of The Medical Science*, May, 1893.)
- Du Lupus secondaire aux interventions chirurgicales sur des foyers tuberculeux, par le Dr. A. Bayet. (Extrait *Des Annales de la Société Belge de Chirurgie*, 1893.)
- On Surgical Diseases of the Neck, by Carl Beck, M.D. (Reprinted from *The New York Medical Journal*, April 29, 1893.)
- L'ictiola nella Theropia delle forme cutanee E Venereo-Sifilitiche. Dott. Reno Segré. (Comunicazione fatta all'Associazione Medica Lombarda nella Seduta del 15 Gennaio, 1893.)
- L'ictiola nella cura della Blenorragia, per il Dott. Pio Colombini. Siena, 1893.)
- Ueber Ichthyolsuppositorien bei der Behandlung der Prostatitis, von Dr. A. Freudenberg. (Sonder abdruck aus dem *Centralblatt f. klin. Med.*, 1893.)
- Ueber die Antiseptische Kraft des Ichthyols, von Dr. Rudolph Abel. (Abdruck aus dem *Centralblatt f. Bakteriologie und Parasitenkunde*, 1893.)
- Pilocarpine, its Physiological Action and Therapeutic Uses, by D. W. Prentiss, M.D. (Reprinted from *The Therapeutic Gazette*, Oct., 1893.)
- Two Cases of Generalized Vaccinia, by T. Colcott Fox, M.B. (Reprinted from the *Clinical Soc. Trans.*, Vol. XXVI.)
- On the Nature of Lupus Vulgaris from a Clinical Standpoint, by T. Colcott Fox, M.B. (Westminster Hospital Reports.)
- Albuminuria without Manifest Organic Renal Lesion, by Waldron B. Vanderpoel, M.D. (Reprinted from *The Medical Record*, Nov. 11, 1893.)

- The Etiology and Pathology of Impotence, by Gardner W. Allen, M.D. (Reprinted from THE JOURN. OF CUTAN. AND GEN-URIN. DISEASES, Nov., 1893.)
- Some Considerations on the Treatment of Cutaneous Malignant Epitheliomata, by A. R. Robinson, M.B., etc. (Reprinted from *The International Journal of Surgery*, 1892.)
- Ueber Russell'sche Fuchsinkörperchen und Goldmann'scher Kugelnzellen, von Dr. K. Touton. (Seperatabdruck aus Virchow's *Archiv Path. Anatomie u. Phys. u. f. Klin. Med.*, 1893.)
- Zur Dermatotherapie des adeps lanae, von Dr. P. Taenzer, Sonder-Abdruck aus Monatsheft. f. prak. Dermat, 1893.)
- Ueber einen Fall Von Cheiropompholyx. (Hutchinson.) Von Dr. Med. Carl Berliner. (Sonder-Abdruck aus der *Deutschen Med. Wochenschrift*, No. 43, 1893.)
- Leukopathia Unguium. B. E. J. Stout, M.D. (Reprinted from *The Medical News*, February 24, 1894.)
- A Case of Ringworm of the Scalp simulating Alopecia Areata, by Henry H. Whitehouse, M.D. (Reprinted from THE JOURN. OF CUTAN. AND GEN-URIN. DISEASES, October, 1893.)
- The Surgery of the Hand, by Robert Abbe, M.D. (Reprinted from *The New York Medical Journal*, January 13, 1894.)
- Sarcoma of the Kidney ; its Operative Treatment, by Robert Abbe, M.D. (Reprinted from *Annals of Surgery*, January, 1894.)
- Sarcoma of the Skin of the Back in a Baby, by W. L. Carr, M.D. (Reprinted from *The Archives of Pediatrics*, December, 1893.)
- The Cutaneous Phenomena of Typhoid Fever, by Joseph Grindon, M.D. (Reprinted from *The Medical Fortnightly*, 1893.)
- Treatment of Syphilis, by Henry H. Morton, M.D. (Reprinted from *The Brooklyn Medical Journal*, 1893.)
- Étude Bactériologique sur le Chancre mou et le bubon chancreux, par W. Dubreuilh et Lasnet. (Extrait, *Archives Cliniques de Bordeaux*, October, 1893.)
- Odd Methods of Syphilitic Inoculation, by William Judkins, M.D. (Reprinted from THE JOURN. OF CUTAN. AND GEN-URIN. DISEASES, December, 1893.)
- Notes on some Urinary Disorders In Out-patient Practice, by Reginald Harrison, F.R.C.S. (Reprinted from *The Provincial Medical Journal*, August, 1893.)
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- Importance to the Surgeon of a Bacteriological Training, by Hunter Robb, M.D. Maintenance of an Aseptic Technique in Gynæcological Operations Outside of Hospitals, by Hunter Robb, M.D. (Reprinted from the *Johns Hopkins Hospital Bulletin*, 1893.)
- A New Spigot Attachment to Facilitate Asepsis, by Hunter Robb, M.D. (Reprinted from *Annals of Surgery*, February, 1894.)
- On the Erythème induré des Scrofuleux of Bazin, by T. Colcott Fox, M.B., etc. (Reprinted from *The British Journal of Dermatology*, 1893.)

- Where to send Patients for Water Cures and Climatic Treatment, by Dr. Thomas Linn. London : Henry Kimpton, 1894.
- Studier öfver Transitorisk Albuminuri. Thorbjörn Hwoss, Stockholm.
- Migration of Syphilis from East Asia into America by way of the Behring Sea, by Albert S. Ashmead, M.D. (Reprinted from *The Journal of the American Medical Association*, February 3, 1894.)
- Ueber den Desinfections werth des Äthylendiaminsilberphosphats und Äthylendiaminkresals, nebst Bemerkungen über die Anwendung der Centrifuge bei Desinfectionsversuchen Von Jean Schaeffer. (Seperat-Abdruck aus der *Zeitschrift f. Hygiene und Infectiouskrankheiten*, 1894.)
- Cheratodermite Simmetrica palmare e plantare da Trofoneurosi. Dott. Alessandro Giletti. Torino.
- Pigmentation of the whole surface of the body, occurring suddenly during the Treatment of a case of Psoriasis. Warty growths upon the Palms and Soles, following the internal use of arsenic, by Albert E. Carrier, M.D. (Reprinted from *The Medical News*, February 3, 1894.)
- Remarks on Alopecia Areata, by P. S. Abrahams, M.D. (Reprinted from *The Medical Press and Circular*, November, 1893.)
- Xanthoma Diabeticorum, by H. Radcliffe Crocker, M.D. (Reprinted from *The British Journal of Dermatology*, No 46, Vol. IV.)
- Tylosis Palmæ et Plantæ, by H. Radcliffe Crocker, M.D. (Reprinted from *The British Journal of Dermatology*, No. 32, Vol. III.)
- Erythema Elevatum Diutinum, by H. Radcliffe Crocker, M.D., F.R.C.P., and Campbell Williams, F.R.C.P. (Reprinted from *The British Journal of Dermatology*, Nos. 63 and 64, Vol. VI.)
- Lupus Erythematosus as an Imitator of various forms of Dermatitis, by H. Radcliffe Crocker, M.D. (Reprinted from *THE JOURN. OF CUTAN. AND GEN.-URIN. DISEASES*, January, 1894.)
- The Prevention of Venereal Diseases, by James T. Jelks, M.D. (Reprinted from *The Journal of the Arkansas Medical Society*, June, 1893.)
- The Antiquity of Syphilis, and Moses as a Health Officer, by James T. Jelks, M.D. (Reprinted from *The Journal of the American Medical Association*, July 22, 1893.)
- Clinical Study and Analysis of 1,000 Cases of Psoriasis, by L. Duncan Bulkley, M.D. (Reprinted from *The Maryland Medical Journal*, 1891.)
- Protozoa and Carcinoma, by I. Adler, M.D. (Reprinted from *The American Journal of the Medical Sciences*, January, 1894.)
- How to Operate for Hemorrhoids, by Chas. B. Kelsey, M.D. (Reprinted from *The Therapeutic Gazette*, April, 1893.)
- Vulvo-Vaginitis in Children, by Edward Martin, M.D. (Reprinted from *THE JOUR. CUTAN. AND GENITO-URIN. DISEASES*, 1892.)
- Gonorrhœal Epididymitis, by Edward Martin, M.D. Reprinted from *University Medical Magazine*, May, 1891.)
- Des Hidrosadénites Suppuratives Disséminées, par le Dr. W. Dubreuilh. (*Arch. de Méd. Experim.*, 1893.)
- Les Doctrines Parasitaires en Dermatologie, par le Dr. W. Dubreuilh. Bordeaux: Imprimerie G. Gounouilhon.
- The Prophylaxis of Gonorrhœa, by Edward Martin, M.D. (Reprinted from *The Therapeutic Gazette*, 1892.)

- Epididymitis caused by Abdominal Strain, by Edward Martin, M.D. (Reprinted from *The Medical News*, 1890.)
- A Possible Case of Anæsthetic Leprosy, by J. W. Winfield, M.D. (Reprinted from *The Brooklyn Medical Journal*, March, 1893.)
- The Caustic Treatment of Cancer, by Daniel Lewis, M.D. (Reprinted from *The Medical Record*, 1892.)
- The Use and Place of Caustics in the Treatment of Cancer, by Daniel Lewis, M.D. (Reprinted from *The Annals of Surgery*, April, 1893.)
- Grefte par approche (Methode Italienne modifiée), par le Dr. O. Guelliot. (Extrait de *L'Union Médicale du Nord-est*, December, 1893.)
- On Lupus, by J. L. Milton. (Reprinted from *The Edinburgh Medical Journal*, December, 1892.)
- Lupus, its Extirpation, by B. Merrill Ricketts. (Reprinted from *The New York Medical Journal*, September 23, 1893.)

### Item.

**International Congress of Dermatology.**—The third meeting of the Congress will be held in London, England, from July 31st to August 4th, 1895. Dr. George Thomas Jackson, 14 East Thirty-first Street, New York, has been appointed Foreign Secretary for the United States to the Congress.







DR. CORLETT'S CASE OF DERMATITIS HIEMALIS.

# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

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### COLD AS AN ETIOLOGICAL FACTOR IN DISEASES OF THE SKIN, WITH A REPORT OF CASES.<sup>1</sup>

BY

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**I**N 1874 Dr. Duhring first called attention to a cutaneous affection associated with cold which has since borne the name of prurigo hiemalis (*Philadelphia Med. Times*, January 10, 1874).

The disease is now well recognized and in certain localities of northern climates is of common occurrence. Closely allied etiologically to this affection, yet presenting some of the clinical features of eczema, are the following cases representing a type which, so far as I am aware, has never received a special consideration, aside from the cases reported by Mr. Hutchinson under the title, *Some Peculiar Eruptions Allied to Chilblains*. (Clinical Lectures, Vol. I.), and more recently *Acrodermatitis of Senility* (Archives of Surgery, January, 1894). Here the characteristic features of the eruption, as well as its association with cold, are clearly brought out; I can not, therefore, claim priority in description. However, as I reside in a locality favorable to its development much opportunity has been given me for repeated observation of the disease, and I trust has enabled me to supplement what has already been written, so that further

<sup>1</sup> Read before the Section of Dermatology and Syphilology, Eleventh International Medical Congress, Rome, 1894.

information may be added, and additional facts may be elicited from members of this Congress representing the most varied climes.

The following cases have been observed in the north temperate zone (lat.  $41\frac{1}{2}$  N., long. 82 W.) on the southern border of the great chain of fresh-water lakes of North America, a region remarkable for wide and sudden meteorological variations which sometimes show a thermometric range of  $40^{\circ}$  in a single day, being in the track of the cold waves or blizzards which, unobstructed, sweep down from the Northwest over the frozen surface of the great lakes.

*Case I.*—C. E., a physician, aged 40, a native of western Pennsylvania, of good general health, consulted me March 3, 1883, for an eruption involving the dorsal surface of the middle, ring and little fingers, extending upward to the wrist, and around the outer side to the palm. The lesion was well defined with an elevated margin, of a dull reddish color and covered with thin, firmly adherent scales. The eruption at times was itchy. Upon inquiry the following history was obtained: The disease first appeared at the age of twenty, during the cold weather, and disappeared the following Spring. The next Winter it returned, occupying the same position and presenting symptoms similar to those observed in the first attack, which, like its predecessor, left at the approach of warm weather. After this the disease returned every Winter, always occupying the same site and going through a regular series of changes, which, as a medical man, the patient had noted in detail. The time of its annual invasion varied in different years and seemed to depend on climatal influences, which were felt only when the thermometer fell to the freezing point.

The first lesions were vesicles which ruptured easily, leaving raw spots; later, a few small pustules occurred which likewise ruptured, giving rise to crusts, and finally these were replaced by scales, as when first seen by me. The patient had noticed that a sojourn to a warm climate, as in Florida, where frost is seldom seen, caused the eruption to subside. Protecting the hand by wearing a fur glove had no appreciable effect. The family history revealed two members on the maternal side affected with eczema. The patient was also under treatment for an inflammatory disturbance of the middle ear. He had never had any eruption on other parts of the body.

*Case II.*—R. J., dentist, aged 48, sought advice for a half-dollar-sized patch on the dorsum of the right hand, December



9, 1884. The eruption had existed many years, appearing only during the Winter months. In character it was thickened, slightly reddish, scaly and with a well-defined border. Moisture had never been a noticeable feature, and itching, although sometimes severe, was not constant. In appearance it resembled lupus erythematosus. This case was under observation several years, during which time it resisted treatment and remained unchanged.

*Case III.*—M. McC., aged 26, seamstress, consulted me in the Autumn of 1887 for an eruption on the back of the hands, which extended down over the dorsal and lateral surfaces of the middle and little fingers. Above, it terminated abruptly at the wrist. In character it was vesicular and at eight o'clock every evening was accompanied by a paroxysm of itching. At other times the hands were tender and the patient was unable to ply her trade. The disease came for the first time in December of the year preceding, but during the Summer it had not been present. It was classed as a vesicular eczema. The patient had mitral insufficiency with marked dyspnœa upon active exercise or after ascending a flight of stairs. The skin of the hands and cheeks was of a dusky, erythematous, at times almost cyanotic, tint. By way of treatment, she was directed to remain quiet. Tonics with the view of strengthening the heart's action were given, and various topical applications were followed in succession, but the eruption did not subside until the following May. It remained away until the Autumn of 1891, at which time an ointment composed of ichthyol 6 p. c., ammoniated mercury 15 p. c. and lanolin 100 p. c., received the credit of curing the attack. On February 23, 1894, the patient again presented herself, but the character of the eruption had changed. Vesicles were no longer present and a well-defined, scaly lesion with an elevated margin covered the dorsal aspect of each hand. The case is still under observation.

*Case IV.*—J. P. N., a police officer, aged 53, sought advice for an eruption on the back of the hands, October 13, 1890, which had appeared every Winter for twenty years. During the past few years the patient informed me it had assumed a dry, scaly aspect, which during the Summer preceding had not entirely disappeared. The disease was accompanied by paroxysms of severe itching which he attributed to change of weather. The patient was benefited by local treatment but before the following Winter died of pneumonia.

*Case V.*—G. F. E., aged 45, manufacturer, of sedentary

habits and a generous liver, first came under treatment January 26, 1891. At that time the patient had what seemed to be an ordinary eczema of the dorsal surface of the hands. The eruption extended upward above the wrists. It was thought the patient's mode of living had an etiological bearing on the case. He therefore was put on a limited dietary and wines and liquors prohibited. Internally he was given small doses of calomel, which was followed by an aperient water. Locally a 50 per cent. lotion of glycerole of tannin was used, which as the inflammation subsided was replaced by the compound menthol ointment.<sup>1</sup> Under this the eruption improved but did not completely disappear until warm weather set in. Although the patient said he had had previous attacks, yet its association with cold did not occur to me until the following Winter, when he again presented himself with a full return of the old malady. At this time he was advised to pass the Winter in Florida, which he did, and the eruption began to disappear after crossing Mason and Dixon's Line and a milder climate was reached. This Winter (1893-4) there has been a tendency for the disease to return, but by anointing the hands with vaseline after bathing the eruption has been held at bay.

*Case VI.*—E. E. S., hardware merchant, aged 46, was seen January 28, 1891. The patient complained of a recurrent disease on the back of the hands, consisting of an erythematous, slightly scaly eruption situated upon a thickened base with well-defined margins and of symmetrical distribution, the history of which he related as follows: During the American War of the Rebellion the patient was confined in Libby Prison. Upon his release he had a severe attack of furunculosis which the following Winter gave place to the present affection; from this he had suffered every Winter since. Although it was relieved and somewhat modified by treatment, it still shows a yearly tendency to return.

*Case VII.*—Miss A. W., aged 22, was seen in consultation March 13, 1891, for a vesicular, circumscribed eruption on the dorsum of hands. There was also a similar spot on the dorsum of one foot. The eruption was peculiar in that the base of the

<sup>1</sup> R. Menthol  
Acidi carbolici  
Sodæ benzoati â â ʒ ss.  
Zinci oxidi ʒ i.  
Ol. amygdalæ dulc. ʒ i.  
Cerat. simp. adde ʒ iiss. Misce.

vesicles was of a dark or raw ham color, accompanied by much smarting and sometimes pain. The patient said at midwinter, when the eruption was most severe, there were sometimes noticed shooting pains from the shoulder to the hand. This was the first attack. The patient then passed out of sight.

*Case VIII.*—F. M. B., aged 26, a clerk, consulted me August 26, 1891, for a condition of the skin which he said became manifest yearly at the first approach of frost. The disease appeared for the first time during childhood while the patient was spending the Winter in Canada. At the time of my observation the skin appeared in a normal condition and the patient's general health was good. He had never suffered from chilblains, and the disease had appeared only on the back of the hands. He sought advice, hoping thereby to avert a return of the malady. He was directed to anoint the hands after washing and protect them with leather gloves. He was seen once or twice during the Autumn; the skin remained normal. I have not heard of the case since.

*Case IX.*—J. N., aged 50, retired merchant, consulted me January 5, 1893, for an eruption on the extensor surface of the fingers. The disease had appeared in much the same form for several years, always showing itself during early Winter and disappearing the following Spring. His general health was good and his habit robust. No cause could be assigned for the condition aside from the influence of cold.

*Case X.*—J. S., aged 47, a railroad conductor, was referred to me by a colleague, January 17, 1893. The patient, who is the subject of the accompanying plate, was in good general health and had never had syphilis, rheumatism nor chilblains. Four years previously he had had an eruption due to wearing new flannels. The present disease began October 28, 1892, in the form of a circumscribed spot about the size of a half-dollar, which came on the left wrist. The eruption was characterized by a roundish, or horse-shoe-shaped, slightly elevated patch containing lentil-sized vesicles which soon ruptured, leaving denuded, dark red or raw-ham-colored surfaces which in its evolution, and taken as a group, bore a striking resemblance to a herpetic lesion. (See Fig. 1.) Unlike herpes, however, there was but little pain, and unlike eczema, itching was not complained of. Soon new lesions appeared on the back of the hands, attaining dimensions varying from a dime to a half-dollar, extending down the dorsal and lateral surfaces of the fingers. The treatment adopted was wholly local: a 50 per cent. lotion of the

glycerole of tannin was applied by means of strips of cotton saturated with the mixture. In healing, the center of the patch first subsided, giving rise to a bluish surface, and leaving a ringed or semi-circular margin. New outbreaks occurred from time to time during the Winter, in which the treatment was somewhat varied, including the internal ingestion of arsenic, potassium iodide and mercury, as well as various topical remedies. It was not until the 5th of May, however, that the hands were entirely



FIG. 1.

free and the patient was able to resume his vocation. During the past Winter the attack has been less severe, and by early attention and repeated anointing it has been held in check.

*Case XI.*—J. R., aged 33, bank clerk, was first seen February 24, 1893. The patient sought relief for an eruption on the back of the hands, extending forward to the dorsal and lateral aspects of the fingers. The feet were involved in corresponding positions. It presented variously sized weeping surfaces, which



involved nearly the entire back of the hands; less extensively distributed on the feet. The eruption appeared for the first time in the Winter of 1881; the patient at the time was living at Bordeaux. It disappeared the Spring succeeding, but returned the following Winter, whereupon the patient left France, returning to his former home in Germany, where he did not have a recurrence of the disease. In 1884 he came to America, and ten days after his arrival in Cleveland the eruption broke out, since which time it has continued to harass the patient during the months of Winter. By way of treatment he was advised to remain within doors with soothing and astringent applications to the parts affected, but before the eruption subsided he was compelled to resume his clerical duties, and not until the 17th of May was he completely free. In the Autumn of the same year (November 16, 1893) he again presented himself with one or two small vesicular lesions on the dorsum of the right hand. It has not, however, during the past Winter assumed a severe form.

*Case XII.*—F. L. I., single, aged 41, a locomotive engineer, was seen December 3, 1893. He complained of an itchy, at times watery eruption on the back of the hands and wrists, which he said appeared every Winter and disappeared with the advent of Spring—this it had done for nine years. There was, in addition, a typical eczematous eruption on the flexor surface of the elbow joints, as well as on the nape of the neck. This latter differed in clinical appearance, healed kindly under treatment, and did not show any tendency to return. The patient attributed the disease to an accident which occurred on February 3, 1883, at which time his engine was precipitated into an excavation, his feet caught in the wreck, where he was held under water, excepting his head, from 2 A. M. until 10 A. M. He retained consciousness only half an hour after the accident. Although not mangled in any way he was unable to resume his work for four months. A fortnight after the accident the skin of the whole surface of the body peeled off; on the palms and soles it was exfoliated in large plaques. One year from the first Autumn following the injury the present disease appeared. Previous to this there had been no history of any skin disease in the family. He had never had any venereal disease. The case is still under treatment.

*Case XIII.*—J. B. H., aged 28, machinist, presented himself February 25, 1894, with a dollar-sized eruption on the extensor surface of the hands and forearms. The case was most

opportune as it enables me to show the disease in its most typical form. (See colored plate.) The eruption stood out in bold relief and presented the dusky red, at times bluish, or purplish hue, according to the position of the hands and the temperature of the room. This feature the artist complained of in selecting the proper color. To better illustrate this



FIG. 2.

the spot (a) was cleared of scales by washing, and (b) was taken after the arm had remained some time in the same position in a moderately cool room. The history, too, was of interest in that the disease first appeared in a mild form eight years before, while he was residing at

Los Angeles, in southern California. He said it looked like a ringworm. There occurred at that time an unusually cold storm which was accompanied by high wind from the north and some snow. The eruption left soon after the weather moderated. The following Summer he moved to Cleveland, where in November the disease again appeared and in the same position, between the metacarpal bones of the index finger and thumb. It disappeared the April following. Until last Winter the eruption has been confined to the right hand; it however, at that time, broke out on the left hand, as herein shown. Preceding its appearance the skin was very itchy; subsequently itching was complained of only during the evening. On the left side, the part last invaded, the spots were more watery and of a brighter color than on the right. The lesion (b) which is the oldest, being a continuation of the original spot, was especially purplish in tint and was more scaly. He has never had an eruption on other parts of the body, neither has he had syphilis, chilblains or any other infirmity.

*Case XIV.*—E. M., actress, aged 28, was referred to me for an eruption on the back of the hands and forearms. The disease came early in the Spring of 1893, she, at the time, was living in Buffalo, New York. It was of short duration, but it again appeared the following December while she was filling an engagement at Cincinnati, Ohio. When the case came under observation, March 1, 1894, it was immediately recognized as belonging to the type herein described. The main lesion consisted of a dollar-sized, thickened patch on the dorsum of the right hand. (See Fig. 2.) It was of a faded rose color, slightly scaly and stood out prominently with an elevated margin. Several smaller spots were scattered over the forearms on both the flexor and extensor surfaces. These latter were of a reddish color, less scaly and had but recently appeared.

The patient came of an eczematous maternal ancestry, but had always enjoyed good health. Her peripheral circulation seemed in a normal condition, although she complained of excessive perspiration of the hands. She had never been afflicted with chilblains. The finger nails were brittle. She is still under observation.

During the past Winter (1893-94) the weather has been unusually mild. But two northwestern storms have occurred, the first in December, when Case XII. presented himself. The

United States Weather Bureau kindly furnished me the following Meteorological Report for Cleveland :

### SECOND METEOROLOGICAL REPORT.

	Mean bar.	Mean temp.	Mean humidity.	Precipitation.
December 1	30.20	22	82	.27
" 2	30.22	16	100	.04
" 3	29.82	28	84	.66
" 17	29.92	26	82	.21
" 18	29.78	28	80	.14
" 19	30.01	26	78	.24

Direction of wind.	Wind velocity.	Cloudiness.
N. W. to S. W.	Brisk to high	10
E. to S.	Light to fresh	8
N. E. to N. W.	Fresh to brisk	10
S. W. to N. W.	Fresh to brisk	10
S. E. to S. W.	Brisk to high	9
S. W. to N. W.	High	10

Maximum temp.	Minimum temp.	Prevailing state of weather.
24	19	Cloudy.
23	9	Cloudy.
34	21	Cloudy.
28	24	Cloudy.
38	18	Cloudy.
27	24	Cloudy.

The second storm occurred February 13th, 14th and 15th, when two additional cases, not included in this report, applied for relief.

	Mean bar.	Mean temp.	Mean humidity.	Precipitation.
February 13	30.12	20	88	.34
" 14	30.18	19	92	Trace
" 15	29.90	21	92	.22

Direction of wind.	Total wind movement.	Cloudiness.
N. W.	229 miles	10
S. E.	172 "	7
N. W.	528 "	10

Maximum temp.	Minimum temp.	Prevailing state of weather.
22	17	Cloudy.
26	31	Partly cloudy.
24	18	Cloudy.

In this and repeated observations we recognize that three conditions are necessary for its production, viz., a low temperature, air in motion and humidity. Again, there is noted



a preponderance of the male sex who are more exposed to inclement weather. No trade or social condition had any noticeable influence. Neither were chilblains nor lupus erythematosus met with in the cases reported.

Prominent among the morbid changes in the skin was the dusky, almost cyanotic appearance of the lesions, which changed in tint according as the position of the hand was raised or dependent. It was also influenced by the temperature of the room. In Case III. there was a marked disturbance of the peripheral circulation, as pointed out by Mr. Hutchinson, but aside from this case no such disturbance was apparent. In the treatment of the disease local measures afforded the most relief. These included emollients, soothing applications and astringents, as were indicated in its different stages. Protecting the surface, although not always effectual, is to be recommended. Failing in these we still possess one panacea—a change of climate.

In conclusion, the cases herein briefly reported present a well-defined type possessing the following distinctive features:

1. Sudden appearance at the approach of cold weather.
2. Spontaneous cure in the Spring.
3. Liability to return in successive years, occupying the sites previously involved.
4. Its characteristic position is the dorsal surface of the hands, next in frequency the corresponding position on the feet.
5. The disease shows little or no tendency to spread to other parts of the body, nor, after the lesions are fully developed, to extend at the periphery.
6. The eruption is characterized by variously sized, round, or, as involution proceeds, horseshoe-shaped patches, which are slightly, sometimes markedly, thickened, having an abrupt, well-defined margin and of a dusky red or slightly erythematous color. At first vesicles are present which easily rupture, leaving denuded, weeping irregular pin-head to lentil-sized surfaces whose color is perceptibly stronger than the surrounding patch and may be likened to a raw-ham tint. The disease at this time often presents a striking resemblance to herpes. Later the patch takes on a faded rose-colored hue and becomes covered with a thin layer of adherent scales, when it might readily be mistaken for lupus erythematosus. This may mark the subsidence of an annual attack, or after many years the eruption may assume this form.

7. Itching may or may not be present; when present it is paroxysmal.

8. Finally, as observed by the writer, the eruption is not associated with any other disease, nor has it been ascribed to any special bodily condition.

With these distinctive characters it seems to me we are justified in looking upon the affection as a disease *sui generis*, to which I would suggest the name most accurately expressive of the condition, *Dermatitis Hiemalis*.

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CASES OF  
PITYRIASIS RUBRA PILARIS (BESNIER).  
ERYTHEME INDURÉ DES SCROFULEUX.  
LYMPHANGIOMA CIRCUMSCRIPTUM.  
MULTIPLE BENIGN CYSTIC EPITHELIOMA.<sup>1</sup>

BY

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Professor of Dermatology in Harvard University.

PITYRIASIS RUBRA PILARIS (BESNIER).

IT is not my intention to reopen before this Association the much-vexed question of the relations of this disease to the lichen ruber of Hebra, which has been the subject of such confusion in the discussions at recent national and international congresses of dermatologists, but to report an interesting case of an affection which is certainly rare in this country. I will merely state in the beginning that I have seen and believe in the existence of that inflammatory dermatosis, lichen ruber, originally described by Professor Hebra, and my opinion that it is in no way related to the keratosis I am about to briefly describe. I desire also to record here my protest against the liberty taken by certain eminent foreign dermatologists in their unrestricted statement that "lichen ruber des Américains" is synonymous with this affection. Some of our writers may hold this opinion, or have confounded the two diseases, but that is a matter of individuals.

The patient was a young lady, twenty-seven years old, who had always had a healthy skin prior to last October. At that time she noticed that her palms and soles were becoming red and scaly. A month later her scalp became "full of dandruff,"

<sup>1</sup> Read before the American Dermatological Association at Washington, D. C., May, 1894.

and her face also turned red and "branny;" she then first noticed the appearance of the papular lesions here and there. Since then there had been a gradual development of the cutaneous changes up to the time when I first saw her, January 10, 1894. Her general health had remained unaffected.

Her face was at this date of a uniform, dull red color, looked glazed, and was slightly scaly and thickened. The whole scalp was covered with a thick layer of scales with very little apparent admixture of fat. The skin beneath them was not perceptibly reddened. The skin of the neck and upper chest, some four or five inches downward, was also uniformly red, slightly infiltrated, and considerably more rough and scaly than the face, possibly because less often washed than the latter. The palms and soles were greatly thickened, of a dull red tint, and the lines of phalangeal flexure were universally marked by deep and painful fissures. The extensor surfaces of the fingers were in a similar condition. The fingers were held in a semi-flexed position, and all movements of the hands and feet caused distress. Walking was very painful. The flexures of the elbows and knees were also converted into red and thickened areas covered with thin scales. These were the only portions of the integument which presented features of uniform, diffused inflammation, viz., hyperæmia, infiltration and desquamation.

Over all other affected parts of the body an entirely different condition existed. The mouth of nearly every follicle was occupied by discreet, firm, horny, hemispherical or conical papules, varying in size from the head of a small pin to that of a large upholsterer's tack. The whole surface of the trunk, front and back was densely studded with them. They covered the entire extent of the legs in innumerable numbers. Upon the arms they occupied chiefly the flexor surfaces. Their color was slightly redder than the general tint of the skin, especially so upon the trunk, and upon some portions of this part of the body they were slightly scaly. The condition of the skin upon which they were seated, the interfollicular areas that is, was apparently normal. There was no marked hyperæmia, pigmentation, œdema, cell infiltration, or desquamation, although it was almost hidden from inspection where the papules were densest and largest. The smallest type of the lesions closely resembled those seen in ordinary cases of keratosis pilaris of the upper arm, but for the most part the trunk and limbs looked like no other dermatosis familiar to us. Considering their condition in connection with the wholly different

appearances presented by the head and neck, hands and feet, we have a *symptomen-complex* which stamps the affection as one of unique and striking individuality. The nails had not undergone any marked change. The only subjective symptoms were a slight, occasional pruritus, and pain on motion of the hands and feet.

I would not be understood to state that a recognition of this disease is always an easy matter. Indeed, some of its phases, according to the locality affected, very closely simulate other affections, and judged by themselves, or before the more characteristic lesions have developed, might readily be mistaken for the former. Thus the scalp closely simulated the appearances of a simple seborrhœa, as it so often does in psoriasis as well. The face might have been regarded as a type of a mild eczema erythematosum, or pityriasis rubra (Hebra). The palms and soles presented the same appearances as in chronic eczema, or inveterate diffused psoriasis. A portion of the upper chest, where the papules were confluent and the redness most pronounced, looked not unlike an area of true lichen ruber acuminatus. The most characteristic lesions themselves, the discrete horny papules of variable size, and of different shades of red, gray and yellow, suggested the kindred disorder of keratinization, the common lichen pilaris and the mildest grades of keratosis follicularis (mine), or ichthyosis hystrix, if the latter two be not indeed identical.

I have met with one other characteristic instance of this disease, and two cases in children of one family not sufficiently advanced to make the diagnosis positive. These have all occurred in the past four years, since I had the advantage of familiarizing myself with its multiform aspects in the incomparable collection of the models made by Baretta to illustrate them in the St. Louis Museum at Paris. It may well be that it is of less rare occurrence in America than the statistics of this association indicate, and that others, as well as myself, may have mistaken cases of less striking individuality than this I now report for some of the affections above named it so strongly resembles.

I will make no reference to the pathology of the disease, which has been so thoroughly studied by Besnier and Boeck.

I would, however, offer a criticism upon the name now attached to it. Its most characteristic lesion, that on which the diagnosis must chiefly rest, the horny papule, is not included in this pseudo-comprehensive descriptive title, and the condi-



tion generally implied by the term pityriasis exists only in the mildest degree, except upon the more restricted localities affected.

It is one more member of the group of keratoses, which demands our careful study.

#### ERYTHEME INDURÉ DES SCROFULEUX.

My attention has been especially held during recent years by some cases of rare occurrence with strongly marked features in common, and which I have not been able to assign to a definite position in our list of recognized diseases. No doubt I had seen them at an earlier period, and had regarded them as anomalous forms of the affections they most closely resemble.

The first case which made itself prominently conspicuous by its individuality was a boy twelve years old, whom I exhibited to my class as a peculiar instance of erythema nodosum. The lesions were deeper seated, of larger size, and were more generally distributed upon the lower legs than usual. They continued to develop, too, over a period of many weeks, and many of them broke down and terminated in deep, indolent ulcers, which were remarkably refractory under treatment. The duration of the whole process I cannot give, as the patient ceased attendance upon the clinic before complete recovery.

The second case was a girl of eighteen, or thereabouts. She came to the out-patient department with a few deeply embedded nodules, the size of a filbert, upon the lower legs, perhaps half a dozen on each. They were all situated upon the lateral or posterior surfaces. A part of them resembled the deeper lesions of erythema nodosum, while others were more like gummata. During her attendance of two or three months similar processes appeared upon the lower extremities, and a few of smaller dimensions upon the arms below the elbows. Most of the former underwent a slow softening, and terminated in deep sluggish ulcers. The movements of her limbs were very painful, and her general condition was poor, so that she was taken into a hospital. While under my care she received a thorough course of antisyphilitic treatment, and the cutaneous lesions such local care as I bestow upon those of similar character in that disease, but without apparent impression upon them. In the wards the affection was regarded as a syphiloderm, and treated accordingly, but with as little response. I am unable to state the subsequent history.

The third case was a girl nineteen years old, and the dis-

ease was confined to one leg. There were at the first visit four or five deep-seated, reddish purple nodules scattered over the posterior surface, which subsequently broke down at considerable intervals, and became exceedingly painful ulcers.

The fourth case was a young married woman, aged twenty-two. She reported that she had a similar attack, although far less severe, five years previously. I first saw her in November, 1893. She then had some half dozen nodules on the lower half of the lower legs, some of which were of two or three months' duration. The youngest of them were of a dusky purple color, while those of longest duration were of a dull brown tint. The largest extended deeply into and below the skin. During the succeeding four months many new lesions developed and underwent various forms of metamorphosis. Some of them softened and sloughed, and were converted into shallow or deep ulcers. Some of them slowly disappeared, leaving superficial depressions without other change in the surface of the overlying skin except in color. The smallest of them disappeared and left only the discoloration. The ulcers were extremely slow to heal, and terminated in depressed and discolored cicatrices. Six months after the beginning of the disease the affected areas were thickly occupied by such lesions, some twenty on each leg, varying in size from a pea to a half dollar, and in color from a livid red to a dark and dirty brown. Two of them only were seated immediately over the tibiæ, none of them were below the ankle. There was one, a small one of short duration, upon the forearm. In their early stages they were exceedingly painful to touch and on motion. One or two of them might have been mistaken by the brightness of their coloring, at first, for the ordinary manifestations of erythema nodosum. The patient was otherwise the picture of health and all her functions were in a normal condition.

Such is a brief account of the course of these cases, all of which had certain marked characteristics in common. The cutaneous lesions, while resembling those of erythema nodosum more strongly than those of any other dermatosis, differed from the same in many important respects. They were generally more deeply seated, as if their starting-point were in the subcutaneous tissues. They were more uniform in size, like marbles or bullets beneath the skin, and rarely presented themselves as small as peas, or like the flattened indurations so often associated with the larger nodules of erythema nodosum. They were more discreet and sparse, too, and were rarely

grouped, as those of the latter often are. Instead of affecting principally the anterior surface of the lower legs, the shins, they were scattered mostly up and down the posterior and lateral regions of the same. In color they were markedly different. In the beginning the overlying skin was often of normal hue, and the nodules were to be discovered only by pressure, or by their slight projection, and only after one or more weeks did it assume a dull red, purplish or brownish color. They never presented the brilliant hyperæmic tints which sometimes characterize the early stage of the lesions of erythema nodosum, nor the later rapid changes of hue suggesting the descriptive title—erythema contusiforme. The course was very different, too, far more sluggish and prolonged. The nodules were sometimes weeks in developing, and months might pass before involution was completed. This might ensue by gradual absorption, but in a large proportion of lesions the overlying integument would slowly soften and break down, and leave indolent deep ulcers. The destruction of tissue was by necrosis rather than by active suppuration. Occasionally the tissues immediately surrounding the nodules, or later the ulcers, would become inflamed, but not often to any wide extent. In all stages the lesions were tender on pressure, but never so excessively so as those of erythema nodosum. When many ulcers existed the limb might become very painful on motion, or when in a dependent position. Eventually the seats of some of the lesions which did not undergo ulceration were marked by atrophic depression, not very different in appearance from the sunken cicatrices left by the ulcers. Both forms were generally surrounded by narrow areas of a dirty brown color of undetermined duration. The general condition of the patients in two of the cases was excellent in the beginning and until strength was somewhat reduced by the long continuance of pain and impeded ability of motion in the open air. In the others the process might have been interpreted from the start as indicative of the impaired vitality which preceded. These patients were anæmic and feeble, although they were free from any serious functional or organic disease. In none of the cases were there any positive indications of the existence of tuberculosis or syphilis. There was a notable absence of all the acute febrile symptoms and of the lymphangitis, which often accompany severe attacks of erythema nodosum.

Now, what is the nature of this affection which has been

observed by dermatologists in France, Germany and England in a sufficient number of instances to warrant its recognition as an independent disease?

Bazin was the first to recognize its individuality, and called it *erythème induré des scrofuleux*. An excellent description of it, with cases, by T. Colcott Fox was published in the August and October numbers of the *British Journal of Dermatology*, under Bazin's title. It has been, no doubt, generally confounded with *erythema nodosum* or syphilis by observers, so that we have no record of its real frequency. Its lesions resemble, too, the so-called scrofulous gummata. But have we any evidence which authorizes us to regard it as a manifestation of tuberculosis? I am not aware of the existence of any. Certainly I should not accept any as conclusive which did not rest upon the demonstration of the presence of the tubercle bacillus in the affected tissues, or possibly upon its uniform association with other forms of tuberculosis in the same individual. No satisfactory examination of the histology or bacteriology of the lesions has been made to my knowledge, and we must await the results of such investigations before we may hope to learn anything definite as to its pathology.

#### LYMPHANGIOMA CIRCUMSCRIPTUM.

In the Autumn of 1892 I saw at my clinic at the Massachusetts General Hospital a man who presented the following appearances:

The left lateral thorax, from the axilla downward to the last rib, and from the nipple backward to the anterior edge of the scapula, was closely occupied by

1st. Groups of prominent vesicles, varying in size from the head of a large pin to a small pea, with very thick and firm epidermal coverings. The contents were colorless or of a dirty yellowish tint, and of rather thick consistence. On the borders of this space the vesicles formed small and sparse groups, but in the central portion they were densely crowded. By rupture they were converted into oozing areas of considerable extent.

2nd. Large elevated crusts, thick and of very firm consistence, of a yellow or reddish color, formed apparently by the coagulation of the contents of the vesicles. They looked not unlike the crusts of an *eczema madidans*, but were much tougher and of prolonged duration. Some of them were two or three inches in diameter.

3d. Crimson elevations of pea size, resembling angiomatous



new growths of cock's-comb character. They were of firm consistence, and became slightly paler on prolonged pressure. They were sparsely interspersed among the groups of vesicles.

4th. Verrucous nodular masses of considerable size and height, some of them capped by dense horny concretions.

The whole inner surface of the upper arm down to the elbow, and connected with the above described thoracic district by a continuous belt through the axilla, presented similar closely crowded lesions, but the crusts were more pronounced and the horny concretions more abundant. The appearances closely resembled those in Morris's plate in the first number of the *International Atlas of Rare Skin Diseases*.

At his first visit the whole integument upon which these lesions were seated was in a state of diffused dermatitis of intense grade and of an erysipelatous type, which extended for a considerable distance upon the chest roundabout.

The patient was thirty-four years old, and he stated that he had had a similar condition of the skin of the same parts when he was ten or twelve years old, and that he recovered under my care, but I find no record of the case at that time. The disease then began, his mother said, upon the arm, where a "congenital lump" existed, possibly a deeply seated nævus. The present condition had been present two or three years, according to his account, and during this period there had been several attacks of the acute dermatitis of brief duration, during which all the various lesions had become greatly aggravated and multiplied. During them, also, there were symptoms of constitutional disturbance, with sensitiveness of the skin and pain on motion of the arm, such as usually accompany superficial erysipelas. At other times, generally that is, the local subjective symptoms were a slight tenderness of the surface over the oozing areas, and a varying degree of pruritus. The general condition of the patient was excellent.

Under my usual method of treatment of erysipelas, the constant application of a lotion of carbolic acid, alcohol and water, the dermatitis quickly disappeared. Soothing and protective dressings were directed to be constantly worn. Under them the vesicles no longer underwent rupture, oozing ceased, and he was able to do his work, that of a motorman upon an electrical street car. In February, 1893, the number of the peculiar vesicles had greatly diminished, the angiomatous (?) elevations were less conspicuous, and the most noticeable lesions were the large, persistent crusts, and the horny verrucous masses.

The patient was not seen again for a whole year, until February, 1894. The appearances had undergone very little change. There had been no recurrence of the dermatitis, and very few new vesicles had developed, he stated. There were few fresh ones visible, situated chiefly at the edges of the thoracic area, and these looked partly dried up. They were of indefinite but long duration. The most conspicuous features were the thick and firm crusts which still covered considerable portions of the affected areas, which had remained for more than a year unchanged, and the closely compacted horny concretions projecting for a quarter-inch or more above the general surface. On removing these by force they were seen to be seated upon prominent spongy bases, which bled freely.

You are all familiar with the recent abundant literature concerning the various forms of disease of the cutaneous lymphatics. Cases have been recorded now by observers in England, France and Germany, and in this country by Elliot, and Epstein. In addition to those of pure varix or cysts of the lymph capillaries we find others intimately connected with similar modifications of the blood-vessels, hæmato-lymphangiomas. Other associated forms of tissue change have also been noted, as angio-keratoma, pachydermia and fibroma. An admirable account of all these varieties will be found in Török's latest article.<sup>1</sup>

The anatomy of my case was studied by Dr. Bowen, who kindly presents the following report:

"A lesion of medium size was removed from the arm and hardened in alcohol. It should be said that the lesion selected was one that did not exhibit telangiectatic points upon its surface, nor was there any infiltration of the base, or warty change. It was selected in default of more varied material, as representing the earlier stage of the process. The chief feature found with the microscope was a collection of chambers, or cysts, lying in the upper portion of the corium and approaching very near to the epidermis, without, however, ever complicating it. These chambers, or cysts, were filled with a very finely granular material, together with an occasional leucocyte, and some masses of fibrine. In many of the sections the contents of the cavities had escaped during the preparation or manipulation. The cavities were often divided into several subdivisions by septa formed of the unaltered

<sup>1</sup> Monatsheft für Prakt. Dermatologie, Band XIV., No. 5.

corium. A well-marked layer of cells could be traced, forming an endothelial lining of the cavities. Some of these cells were rounded and full; others were of a spindle shape, or slightly flattened. There could be no doubt that these cavities were newly formed or dilated lymph-vessels and spaces, and this was proved conclusively by the fact that they could be seen to communicate with smaller, more regular channels below, which were evidently a part of the lymphatic system. There were considerable collections of round cells about these dilated or hypertrophied lymphatic vessels and spaces, but none in other parts of the corium. In the lesion examined but few enlarged blood-vessels could be seen. Those that existed were usually situated in the corium below or at the side of the lesion, none above it. The epidermis was thinned over the lesion, the lower rete cells being flattened and compressed. The papillæ had disappeared in great measure. At the borders of the lesion, however, the interpapillary epithelial prolongations were considerably lengthened.

"The histological structure, therefore, accords perfectly with that of the cases of circumscribed lymphangioma that have been described. It is not possible to form an intelligent opinion from the study of a single lesion as to whether there exists here a simple dilatation of pre-existing lymph channels, or whether there is a new growth, as is claimed by most recent writers. My impression is favorable to the latter view."

The secondary lesions in my case, the verrucous elevations of great prominence, with their horny coverings, which form so conspicuous a feature in advanced stages of the disease were such as are found upon the lower extremities so commonly in elephantiasis. Very likely the recurrent dermatitis conduced to such hypertrophy of the superficial layer of the cutis. It is notable, however, that in spite of such attacks of erysipelas-like inflammation there was no pachydermia or true elephantiasis of the cutaneous tissues in general, as has been observed in other instances.

#### MULTIPLE BENIGN CYSTIC EPITHELIOMA.

I desire to report a case of this rare and much betitled affection, because one of the features it presents is unique and belies one of its descriptive names. The patient is a woman, forty-five years old, who was born in Stuttgart, and came to Boston thirty years ago. She was married at the age of twenty-two, and has had eleven children, of whom only three

survive. The oldest of these is sixteen. They have healthy skins, and her relatives, so far as she knows, have been free from any form of cutaneous or carcinomatous disease. The first change in the condition of her skin noticed was at the age of twenty-four, when a few firm "pimples" of the same color as the skin appeared, scattered over the face. These never disappeared, but grew slowly larger, and others of the same character continued to develop up to three years ago. Some of them, she says, began to soften ten years ago, and of these several were removed by caustic plasters from time to time, leaving flat scars to mark their former seat. Within the last two years her general health has failed, so that she has been largely confined to her house. The menstrual function is still active.

*Status præsens.*—The patient is pale, but well nourished. The face presents some fifty lesions, which may be classified as follows: (Fig. 1.)

1. Flat papules or tubercles, varying in size from the head of a large pin to a split pea. They are of the color of the skin, and of about the same consistence. The smallest are only slightly elevated, and would scarcely be noticed except on close inspection.

2. Larger lesions, varying from pea-size to that of a dime, one of them as large as a quarter dollar, circular or ovoid in shape, but still not much more elevated than the smaller ones. They are all redder, however, than the latter, and the largest very much so; their surface is still smooth and level.

3. Others of medium size and upward, which are either somewhat depressed in the center or have begun to soften and be covered with dull brown crusts of no great thickness.

None of these first three groups have a central opening.

4. Two or three lesions much more prominent, and presenting abrupt perpendicular edges and depressed centers, closely resembling Hutchinson's crateriform epitheliomata. These measure from one-half to three-fourths of an inch in their longest diameters.

5. The right upper eyelid is occupied by an irregular elongated ulcer, partly covered by a crust, with deeply infiltrated margins, so that the lid can be only partially elevated. The inner third of both lids of the left eye and the side of the nose adjacent are the seat of open ulceration, by which all the cutaneous tissues have been destroyed. The inner outlines of this area are marked by an elevated narrow margin of great hardness. The whole presents the characteristic appearance of



the "rodent ulcer" type, and is the seat of frequent hæmorrhage. This eye is closed.

6. Scattered and smooth scars of irregular outline, where former lesions have been destroyed by caustics.

There are a few of the larger lesions also upon the neck, shoulders and forearms, but none of these have undergone any secondary transformation.

All of them are free from subjective manifestations, excepting the open ulcers about the eyes, which are very painful. The flow of tears over the open wound is very distressing, and there is often intense headache, described as penetrating from this locality inward.

You are familiar with the large number of names which have been given to this affection by the observers of individual cases, and which represent their respective views regarding its anatomy. It may be instructive to reproduce them here :

Hydradénomes éruptifs, Darier.

Cystadénomes épithéliaux bénins, Besnier.

Epithéliome kystique bénin, Jacquet.

Cellulome épithélial éruptif kistique, Quinquaud.

Gutartige epithéliom, Phillippon.

Syringo-cystadenom, Török.

Lymphangioma tuberosum multiplex (?), Kaposi.

Epithelioma adenoides cysticum, Brooke.

Multiple benign cystic epithelioma, Fordyce.

These titles clearly indicate the nature of the anatomical changes which characterize the disease, and the diverse interpretations which have been placed upon them by different observers. No one of them has studied it more carefully than our valued colleague, Dr. Fordyce, whose admirable communication upon the subject to this Association, at the meeting of 1892, you must well remember. I have the pleasure of exhibiting to you some micro-photographs of sections from his cases made subsequently to that date. An examination of the structure of the growths in my own case has been made by our fellow member, Dr. Bowen, with his usual care, the results of which I will now present.

"Four lesions of different sizes were removed from the face and hardened in alcohol. Two of these, the smallest and one of the larger lesions, were stained *in toto* in alum, cochineal and rosin, imbedded in paraffine, and serial sections through the entire nodule obtained. Sections from the smaller lesion, which was not much larger than the head of a pin, showed,

under the microscope, a compact area of epithelial cells lying in the upper portion of the corium without any distinct arrangement. This mass of epithelial cells was irregularly rounded in its outline, and the individual cells were seen to be of a similar appearance to those of the lower rete layers. On examining the sections mounted in series, those at the edges of the little tumor showed simply this nest of epithelial cells lying in the corium, and separated by a small belt of normal tissue from the epidermis. In many sections, however, especially in those near the center of the nodule, there was a distinct connection between the lower rete cells and this epithelial area in the corium. (Fig. 2.) The epidermis, apart from this connection with the misplaced epithelial focus, was essentially normal. There was no connection between the epithelial area and the sebaceous, or sweat glands, which were, so far as could be seen, normal. One lacuna, round in shape, was present in this lesion in the midst of the epithelial area. Its walls were made up of a thin layer of flattened cells, so that it had the appearance of a cyst from which the contents had escaped. In one or two of these sections a small amount of corneous material was seen in the interior. The epithelial cells in the affected area were well stained, and no other appearances than occasional karyokinetic figures seem worthy of comment.

“In the other three lesions examined, which were all somewhat larger than that just described, a rather different picture was found. Epithelial masses in the corium were here also the essential feature, but a distinct arrangement in islands and elongated tracts was noted, the latter often suggesting, when seen with a low power, the course of a sweat-gland. With a higher power, however, these tracts were seen to be made up of compact masses of epithelial cells, and to be connected and intermingled with one another in a very complicated way. In the midst of these epithelial bands and islands small cysts were frequently seen, containing a granular or homogeneous substance, together with one or two large, deeply stained cells. In one of the lesions these small cysts were quite numerous, and in places the outline of epithelial cells could be traced which had lost their power of staining, and were evidently being converted into the homogeneous or colloid substance which occupied the interior of many of the cysts. In a few of the cysts, it should be added, a corneous substance was present in place of, or together with, the colloid change. In all of the tumors *a connection of the epithelial masses and tracts with*



FIG. 1.  
MULTIPLE BENIGN CYSTIC EPITHELIOMA.

*the lower cells of the rete* could be demonstrated in some of the sections. There was no proliferation of the glandular structures found."

First described and individualized in 1887 by Jacquet and Darier in France, the affection has been recognized to exist sparsely in all countries where there are dermatologists of sufficient experience to distinguish it from other dermatoses which it most closely resembles, and with which no doubt it had prior to the above date been confounded. But it can scarcely be claimed that we are yet completely acquainted with its clinical features. Considerable variation has been noticed in the course, seat and macroscopical appearances of the small number of cases which have fallen under observation; but this case differs widely in some particulars from any of those previously recorded. The lesions vary more in size, many of them far exceeding the dimensions previously noted. Thus Brooke says they never exceed the size of a pea. Fordyce mentions one in the mother's case as large as two peas as exceptional; other writers speak of groups of confluent lesions. In my case several of the lesions were half an inch in diameter, and one of them was an inch across. There were lacking in them the appearances described as embedded milia, and the black points or dots beneath the skin recorded in some of the other cases. Nor did any of the lesions have a noticeably translucent look, or exhibit in a marked degree the telangiectases mentioned by others. Their seat was principally the face, as in Brooke's and Fordyce's cases, but the neck, upper trunk and arms were also sparingly affected. There were none upon the scalp.

The most remarkable feature in my case, however, was the transformation in the oldest and largest lesions. Three or four of these had, in recent years, taken on the appearance of ordinary epithelioma in several of its advanced clinical phases, viz., scaling, crusting, and open, deep ulcerative destruction of the whole skin. If any one of the latter were alone under observation no other diagnosis than ordinary epithelioma would be entertained, whereas the great bulk of the lesions were just like those hitherto recorded as characteristic of the affection, the identity with which is fully established by the investigation of Dr. Bowen above given. How, then, shall we account for this highly important deviation in course and prognosis from any of the other cases, which seems to belie, as I have expressed it, the accuracy of the paradoxical claim that here is a disease characterized by tissue changes universally regarded hitherto





FIG. 2.

SECTION OF MULTIPLE BENIGN CYSTIC EPITHELIOMA.

as malignant, and yet possessing indefinitely a benign character? Is it that some of the lesions in this case have undergone, by chance, as it were, a secondary malignant transformation, as the long-standing lesions of keratosis, verruca, tuberculosis and other benign dermatoses are known to do occasionally, or is it rather that this is to be the eventual fate of more or less of the lesions in every case, and that future reports will show, when sufficient time has elapsed in the history of all of them, that epitheliomatous tissue is bound in time to go to the bad? I am inclined to this latter view. Ten years ago, when this patient was thirty-five years old, every lesion would have appeared as "benign," as all those described in all other recorded cases, as the great majority in fact of those in my own case. The natural tendency of such modified epithelial tissue out of place to self-destruction will probably assert itself when it has encroached upon the normal cutaneous structures in such large accumulated masses as in this case, or when after middle life the vitality of the elements of both is impaired. The only record of a similar transformation is in the report of a case of "Hydradenom," by Hallopeau, in which one of the tumors on the eyelid became "epitheliomatous." It is to be hoped that the reporters of all recorded cases will hold them under prolonged observation, and publish their future history. In the meantime, the correctness of the appellation benign must be regarded as problematical.

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#### THE QUESTION OF SURGICAL INTERFERENCE IN TUBERCULOUS KIDNEY.<sup>1</sup>

BY

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OF one hundred and seventy-four cases observed by me sufficiently to justify the positive diagnosis of tubercular disease of the urinary organs, only eighteen gave unmistakable evidences of involvement of the kidneys.

This statement is, of course, intended to apply only to cases of surgical, as distinguished from that more generalized tuberculosis known as miliary, and this distinction is applicable to all that follows. Neither in my notes nor within my recollec-

<sup>1</sup> Read before the American Association of Genito-Urinary Surgeons, at Washington, D.C., June 1, 1894, Congress of American Physicians and Surgeons.

tion is there a single case where the disease was primary for the body in the kidneys, and I cannot elicit from these any figures as to the relative frequency of the primary infection of these glands in the uro-genital cycle. In a majority of the cases of renal tuberculosis, the bladder gave the first clinical signs of mischief, and without any exception the lower urinary, and in males frequently the genital organs were distinctly involved when first seen by me; but in a certain proportion of the cases the middle urinary passages were infected in a manner to fully justify the belief that the disease came to them from above, *ex. gr.*: in those striking cases of surface infection of the vesical outlet the trigone and ureteral orifices which one sees conjoined with renal tuberculosis, and which, under observation, glide steadily into unmistakable vesical tuberculosis, often spurred into activity by injudicious instrumentation. So that from the clinical, no less than from the pathological and ætiological points of view, one must concede, for the uro-genitalia, a primary renal infection.

How long the disease remains in the kidneys before infecting the lower urinary passages, is of surgical interest chiefly in connection with the possibility of forestalling its spread by an operative procedure. My own observation is distinctly to the effect that the lower urinary passages and frequently the prostate and seminal vesicles are infected long before there exists a satisfactory reason for surgical intervention, and this accords with the opinion of H. Eilers, whose researches convinced him that the prostatovesicular region was never missed in tuberculosis of the uro-genitalia.

Of the eighteen cases of chronic or "cheesy," or "strumous" tuberculosis of the kidney, three only presented a symptomatology, which justified me in proposing an operation for relief, and in each case the suggestion was, after a candid statement of the probable results, promptly adopted by the patients.

Briefly related, these are as follows:

*Case I.*—James F., æt. 46; merchant; widower. Good family and personal history. Seen by me in the Spring of 1888. Had gonorrhœal urethritis twice before he was twenty-five, the last case being rather prolonged, but not extending to the bladder or testis. History of increased frequency of urination—both day and night—for past four years, and of irregularly occurring hæmaturia preceded by pain in left loin, for past four months. Blood intimately mixed but not bright.



For the past two weeks has had several attacks of left renal colic, quickly followed by chills, high fever, vomiting and anorexia. Observes that at these times the urine voided is almost clear, frequency much lessened and quantity diminished, this condition persisting for three to ten hours, when a large quantity of cloudy, reddish brown urine is passed, followed by relief of pain and subsidence of fever.

Two such attacks occurred during the time he was under observation at the hospital before operation. Physical examination revealed tuberculous nodules in both seminal vesicles, and in the right prostatic lobe, the right seminal vesicle being much distended on account of obstruction to its duct; distention reflex much exaggerated, even under anæsthesia; testes, cords and anterior urethra normal, deep urethra hyperæsthetic and bleeding on instrumentation. Cystoscopy showed patchy, disseminated cystitis about the base, sub-mucous hæmorrhages surrounded by red patches and ramified blood-vessels. Left ureteral orifice surrounded by dark red granular spot, the right orifice not made out. During the second cystoscopic examination I made an interesting observation. While observing the left ureteral opening, a dirty, brownish shred was seen apparently hanging out of it. By gently moving the cystoscope, this could be made to shift its position, but one end seemed to hold fast to its attachment. Suddenly it stood erect, trembled and passed out of the visual field, which became too cloudy for further observation. I interpreted this, of course, to mean that the current of cloudy urine had at that moment passed down from the left kidney, swept away the shred and clouded the adjacent water.

Urinalysis showed a nearly normal sp. gr. and quantity, cloudy, brownish red, full of shreds and yielding a sediment made up of more or less disintegrated blood, pus and epithelial cells. Tubercle bacilli in moderate amount. No tubercasts; albumen in considerable quantity. Oxalate of lime crystals were rather abundant.

Operation; lumbar incision; perirenal fat condensed and scanty. Kidney normal in size. On attempting palpation, the finger sank through a pulpy mass occupying the site of one of the upper posterior cones, easily passing into the corresponding calyx. Perhaps a tablespoonful of pulpy, gritty substance was removed with the finger and by gentle curetting.

The renal pelvis was cleared out with a stream of hot water,



which was made to pass down and out of a catheter inserted into the bladder, a drainage tube put in, the wound stuffed with gauze and the lumbar fascia sewed with catgut. Gauze removed on the third day, after which a considerable quantity of bloody urine came by the lumbar opening. This suddenly ceased on the fifth day, to be followed by left renal colic, a chill and fever, then bloody urine, a clot and a subsidence of all bad symptoms.

The patient left the hospital at the end of five weeks, the lumbar wound closed, much improved in weight and health, but with no great improvement in his bladder symptoms. These last persisted when I heard from him in the Fall of 1890, but were not seriously inconveniencing him. There had been no return of renal symptoms.

*Case II.*—C. J. P., auditor of R.R. Co. Seen by me first November 27, 1892; æt. 27.; married; family history good. No tuberculous disease. Personal history good, gonorrhœa twelve years before. No complications. No history of passage of gravel. Nineteen months ago noticed increased frequency of urination, followed in three months by left renal colic. One month later hæmaturia first appeared after instrumentation for supposed "stricture at neck of the bladder." Left renal colic appeared at irregular but shortening intervals after this, and the last attack was accompanied by chill and fever. Urinates hourly at night and every two hours during the day. Examination revealed tuberculous nodules in seminal vesicles and prostate, and most likely surface infection of vesical neck by stream of tuberculous urine from left kidney. Cystoscopy impossible on account of bleeding. Urinalysis: sp. gr. 1012—neutral—2 per cent. (moist) albumen, much pus, blood cells, scanty epithelia, no renal element, no casts, no tubercle-bacilli. Tenderness in left lumbar region. Pain radiates to testis and causes retraction.

December 6, 1892. Left renal colic, urine cleared, slight chill in two hours followed by fever, sweating, subsidence of pain in left loin and clouding of urine. Similar experiences on 9th, 10th and two on the 11th of December. Passed shreddy and cheesy mass on the 14th. These symptoms continuing, he went to hospital on the 16th and on the 20th the kidney was exposed by a lumbar incision. It was found to be normal, so far as could be discovered by palpation and puncture.

The perirenal fat was almost entirely absent. The pelvis

and as much of the ureter as could be reached by the finger, was thickened and nodulated. The parts were quite firmly fixed in the loin and I feared that an attempt to lift the kidney from its bed and draw it into the wound would result in lacerating the ureter, so, after satisfying myself by puncturing with a fine needle that the nodules in the pelvis were not calculous, the wound was closed over a drainage tube, and healed in a satisfactory manner. On the 25th of December colicky pains along the ureter returned with retraction and pain in the corresponding testicle. These recurred every day or two, accompanied by fever and the passage of small blood clots until January 9th, when they ceased, and did not return again. The patient left St. Louis in February, 1893, much improved by general anti-tuberculous treatment, and resumed his business in the South for a few months. Soon the bowel and peritoneum showed signs of infection, and he died of general tuberculosis in February of 1894. An autopsy was made and I learned, indirectly, that the left kidney was almost destroyed by ulceration, the perirenal region extensively infected and the right kidney considerably damaged.

*Case III.*—Bernard B., æt. 32., German, farmer, married. No history of venereal disease. No family history of tuberculosis. Patient was well and strong up to the age of eighteen, from which time until he was twenty-one he had several attacks of right renal colic, accompanied by nausea, vomiting and pain radiating toward pelvis, but not by any retraction of the testis. These attacks were followed by hæmaturia lasting a short while only. From his twenty-first to his twenty-seventh year these acute attacks subsided, but riding horseback always produced a dull aching in right kidney region. In his twenty-eighth year, these symptoms recurred. In December of 1892 patient had a severe and prolonged attack of renal colic followed in eight days by the passage of a small calculus by the urethra. From that time until I saw him on March 3, 1893, pain, hæmaturia and pyuria had been quite constant.

I may remark here that I had removed a large calculus from the left kidney of this man's father (æt. 59) in 1890, and on his recovery the son was brought to me for examination on account of a long-standing frequency of urination. At that time there was tubercular disease of the prostate, hæmaturia and pyuria, and the bacilli were demonstrated in the urine.

By March the 11th, 1893, there were present all of the symptoms of an abscess of the right kidney, imperfectly draining

through the ureter, and the constant fever with pain, swelling and fluctuation in the loin indicating a perinephritic abscess, the lumbar incision was made. A large post-renal abscess with shaggy walls was opened first. This being cleaned out, the posterior surface of the kidney came into view, but was fixed rather firmly by perirenal adhesions. Careful search revealed an opening on the outer border of the kidney which extended into the pelvis and easily admitted a forefinger, with which it was explored. The cavities were cleaned, washed and stuffed with gauze, proper drainage being provided for. On the 15th it was noted that more pus than urine was flowing by the lumbar incision. On the 18th examination under chloroform showed that the kidney wound was covered by soft granulations which bled on the lightest touch, and that the post-renal abscess cavity was enlarging by ulceration in all directions. On the 22d diarrhœa indicated a bowel infection.

At 6 P. M., on the 27th, a chill, followed by high fever, cough, bloody and purulent expectoration and dullness over the lower portion of the right lung, showed that the chest cavity had been reached. This was followed by evidences of peritonitis on the 29th, though the freest possible drainage was maintained. The patient died on the 30th, and a partial autopsy on April 1st revealed tuberculous ulceration of the pelvis of the right kidney. Two small calculi, one in the upper and one in the lower part of the pelvis, had escaped detection by reason of their lying in deep ulcerations. The left kidney contained two small tuberculous foci with cheesy centers and its pelvis was dotted with miliary nodules.

These cases were operated upon by me with the full conviction that tuberculous disease was being dealt with, and the impelling motive was the evidence that I had that cheesy, sloughing inflammation and abscess were progressing in kidneys that were not adequately draining by way of their ureters. In Case I. the condition found and the result obtained fully justified the interference. In Case II. the anatomical diagnosis on the one hand and the failure to open and drain the renal pelvis on the other, lie open to criticism. A number of observations made by me have led to the conviction that when, in kidney colic, the pain shoots quickly into the testis and causes its marked retraction, the obstruction, ulcer, or whatever is at the bottom of it all, is situated low down in the ureter; but that the cause of the trouble is high up toward the kidney or in that organ when, in the absence of this set of symptoms, the

pain quickly passes to the opposite side and causes nausea and vomiting. Seeing that in the subsequent course of this case the disease passed toward generalization by way of the peritoneum, it appears most probable that the greatest mischief and especially the sloughing, was going on in the middle or lower third of the ureter. Had cystoscopy been possible, the error in diagnosis would doubtless have been avoided.

After the kidney had been exposed and the condition of its pelvis and the upper end of the ureter made out, an aspirating needle was inserted and a little purulent urine withdrawn. In the face of this evidence of suppuration and, probably, ulceration of the pelvis, incision and drainage were decided against on the ground that infection and destructive ulceration of the wound would most probably result. It was thought best to take the chances of an opening up of the ureter below, a hope that was justified, for after a few more attacks of colic the tube gave no more trouble by being blocked.

Indeed, it has been my observation that tuberculosis, by reason of its destructive tendency, does not tend to block a duct except temporarily by casting off sloughs, and does not at all tend to stricturing. In such cases a stricture could not begin to form until healing and cicatrization were well advanced. Finally, I can see no reason to believe that the tuberculous ulceration in the pelvis of the kidney would have been in the least benefited by the presence of a drainage tube through the loin. In Case III. the danger incident to the infection of the circumrenal tissues is markedly apparent. It is possible, but by no means certain, that an operation done relatively to the progress of the disease as early as in Case I. might have been equally beneficial.

Cases I. and III. evidently began and progressed in the same way. A cheesy focus formed at the base of one of the pyramids and progressed in both directions, viz.: toward the papilla and cortex. In Case II. either the infection was earlier or the progress of the disease more rapid in the ureter than in the renal pelvis.

Surgical interference in tuberculous disease of the kidneys has been recommended, (1) to clear up diagnosis and remove possible stone, (2) free sloughing portions of the renal substance, (3) to drain the renal pelvis and avoid the infection of the lower urinary passages by diverting the stream of tuberculous urine by the loin, (4) (splitting the capsule) to avoid extensive sloughing in cases where the onset is sudden and large



portions of the organ are threatened, and (5) (nephrectomy) in cases where the kidney is sufficiently disorganized by "strumous" disease to be no longer useful as an excretory organ and to threaten the general health.

The complexity of the problem of surgical tuberculosis, the fact that an experiment is not an adequate substitute for experience and the knowledge that here we are dealing with organs so essential to the maintenance of life, render it impossible to study these propositions otherwise than by trial, that is to say, by the light of what has actually been done, and the results that have followed this doing. And of this sort of evidence we have but a meagre store, all too small to warrant generalizations in the face of well-known abundant sources of error.

The researches of Morris, Dickinson and Steinthal, embracing 134 cases in all, show that in a very little more than fifty per cent., both kidneys are diseased, though not to the same extent. This is sufficient to warn against any serious interference with the diseased organ except in cases of urgent necessity, and gives point to the remark of Morris (p 482) that "it is in scrofulous kidney especially that we so much need the means of ascertaining the working capacity of the second kidney, and it is in these cases also that the difficulty of so doing is almost insuperable." And not only may the second kidney be diseased, but it may be absent, and even if present, and not diseased at all, there can be little doubt that other tuberculous foci exist elsewhere in the body, and though "latent" are ready to become active sources of infection at any moment. An analysis of twenty-four cases of cheesy tuberculosis of the kidney by Steinthal led him to the conclusion that in all such cases there was also tuberculosis of the lungs or bronchial glands, and that this was the primary lesion for the body, though it might be latent. Merely draining a tuberculous cavity in any part of the body has not proved a satisfactory proceeding in my observation, even when the drainage was complete or combined with washing and the application of antiseptics. This, and the now well-known fact that cheesy tuberculosis, like syphilis, has its periods of repose ("latency") and periods of activity, make it easy to mistake an improvement following an operation for consequence rather than a sequence, which it often is, and renders the term "recovery," as applied to those who have been operated on, of doubtful significance. If we may reason by analogy from similar conditions

of the testis, splitting the capsule in those cases of sudden onset with rapid swelling in order to prevent considerable destruction of gland tissue is not so effective as rest with emollient and anodyne local applications. In the only case where I saw this done for the kidney the patient died in a fortnight from general tuberculosis. Where the symptoms of stone were fairly clear an operation for its removal seems to be justifiable, but the danger of lighting a chronic into an acute renal tuberculosis is too great to justify an operation for the purpose of clearing up a doubtful diagnosis when intelligent watching and patient waiting will surely, in the great majority of cases, solve the problem.

To remove a stone; to open an abscess that is not adequately draining by the ureter, and thus relieve fever and wasting suppuration; to free sloughing portions of the kidney and thus prevent infection of the pelvis and peri-renal tissues, and, when we can satisfy ourselves reasonably well of the adequacy of the opposite kidney, to remove the one that is disorganized and causing wasting by suppuration, seem to me to be plain surgical duties; but to remove or even to incise and drain any portion of a kidney with the object of removing a focus likely to infect the body is not, in my judgment, a justifiable proceeding.

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## Society Transactions.

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### THE AMERICAN DERMATOLOGICAL ASSOCIATION.

EIGHTEENTH ANNUAL MEETING. HELD AT WASHINGTON, D. C.,  
MAY 29, 30, 31 AND JUNE 1, 1894.

DR. GEORGE T. JACKSON, *Vice-President, in the Chair.*

(*Concluded from page 432.*)

DR. BRONSON said it would seem that the case of pityriasis rubra pilaris was not absolutely typical, although its features were sufficiently characteristic. The inflammatory symptoms are usually not so marked as in Dr. White's case. It would seem as though there was some complication in the present case. The fissuring and erosion about the palms was suggestive of eczema. One of the most characteristic signs in connection with the disease is the occurrence of little horny papules on the backs of the fingers. This was absent in Dr. White's case. With regard to the name he failed to see why it should be called pityriasis. The disease is, to all intents, a lichen.

With regard to the second case stated by Dr. White, as *erythème induré des scrofuleux*, it strongly suggested what has been described by

Mauriac and others as syphilitic erythema nodosum. The question is whether it is not an erythema excited by some other analogous condition, such as scrofula or tuberculosis.

In regard to the last case, he thought it seemed like a rare form of lupus erythematosus.

DR. SHERWELL agreed with Dr. Bronson that in its early stages the eruption looked more like a lichenoid than a pityriasis disease, although he did not concede that it was related to lichen ruber. The name was not a happy one.

DR. DUHRING also thought there were features in the case not usually met with. He had been struck with the fact that the disease presents a distinctly different appearance as it occurs on different parts of the body, especially upon the hairy or non-hairy parts. The first case he had observed was diagnosticated as being probably a follicular psoriasis. When occurring on the hairy parts, as for instance the back of the hand, it has distinctive features, which are wanting when it occurs on some other parts, as, for instance, the forehead.

The idea of lichen never occurred to him, therefore he cannot agree with Dr. Bronson or Dr. Sherwell that it may be allied to lichen. The cases he had seen have been distinctly milder in type than most of those reported, and the milder treatment that is employed in psoriasis seems to answer well. The disease may pass off and recur after an interval of two or three years. While the term is not acceptable, he thinks it advisable to retain it for the present.

DR. HYDE wished to confirm the statements made by Dr. Duhring. If one of the patients is presented before a clinic of senior medical students they would at first pronounce it a case of psoriasis. Only an expert would recognize the special process which furnishes the great points of difference. Dr. White's case is clearly one of pityriasis rubra pilaris. The minute blackish points upon the dorsum of the phalanges is characteristic. The French lay great stress upon this as a diagnostic feature.

There is objection to any lichenoid title for the disease.

DR. HARTZELL: As to the *erythème scrofuleux* he had seen a case of this kind some years ago, and had made sections of some of the lesions, finding the histological changes such as are found in tuberculous lesions.

The clinical features were those which have been described.

DR. STELVAGON: Pityriasis rubra pilaris was a condition that he never recognized until seeing the case Dr. Hyde showed at Milwaukee. He had seen a case since in which the eruption developed rather suddenly, in the course of two or three months, involving the whole scalp, and presenting here the appearance of psoriasis; the lichenoid appearance was also noticeable.

DR. ZEISLER suggested the name *keratopityriasis rubra pilaris*, on account of the peculiar condition presented in Dr. White's case.

DR. WHITE: The negative evidence, considering the sparseness of the bacillus in some forms of tuberculous growth, would seem to offset the evidence which Dr. Hartzell offers on the other side. He did not think it possible to confound this disease with *erythema nodosum*.

With regard to Dr. Bronson's suggestion of lichen, it depends upon the definition of lichen; if he means simply a papular disease, it is right; if he means an inflammatory disease it is wrong, as there is no inflammation.

He did not think that this case, nor the three or four others that he had seen, could be mistaken for psoriasis. The scales which cover these inflamed non-hairy parts, though they might look like diffused dermatitis, would not suggest psoriasis: it is more a condition of pityriasis.

**Acquired Idiosyncrasy for Quinine, Showing Peculiar Cutaneous Manifestations.**—By DR. C. W. ALLEN, of New York.

A man who had previously always been able to take quinine developed his first eruption from five grains of the sulphate, and for a number of years had the same erythematous and occasionally bullous eruptions in the same locations whenever as small a quantity as  $\frac{1}{16}$  grain was given by mouth, rectum, or through the skin. With the man's consent, Dr. Allen carried out a series of experiments extending over several years, to determine if possible the manner in which the drug acted to produce this effect. The conclusion reached was that the drug in this case probably affects primarily the cord in the upper dorsal region, and he thinks that this, if verified in other instances, may lead not only to a clearer understanding of certain skin diseases of obscure origin, but may also explain how quinine acts to produce some of its therapeutic effects.

In Morrow's work on drug eruptions it is stated that all that is required in the treatment is the withdrawal of the drug. This would give the impression that the eruption disappears immediately upon such withdrawal; but such is not the case; it does not disappear immediately, and sometimes does not, indeed, appear at all until after the drug is withdrawn.

DR. HYDE said that in one case prominent before his mind, the symptoms were much more extensive than in the sketch which had been passed around. In that case the spots appeared over the whole surface of the body after the injection of two grains of quinine. A young man had presented himself to the speaker with the representation that he was a subject susceptible to quinine, and offered to show the eruption to the class at the college. He took the alkaloid, but the usual eruption did not follow. He had lost his susceptibility.

DR. GRINDON had oftenest seen the urticarial, and not the erythematous type, and had noticed frequently a family susceptibility, being acquainted with a family who all possessed it and all manifested the urticarial type, the eruption reappearing at the same spot, behind the ears, and on the sides of the neck.

DR. WHITE had applied once as a wash to the scalp a solution of ten grains of quinia in eight ounces of alcohol. After one application was made the patient was covered with an erythematous eruption, like scarlatina. She told me that she had been poisoned twice before by taking quinine.

DR. STELWAGON had observed a case in which a tenth of a grain of cinchonida, repeated three times, produced an eruption resembling eczema. The gentleman had had several attacks before; mental impression was excluded. The effect did not disappear immediately after the drug was withdrawn; in fact not till after three to six weeks.

**A Case of Symmetrical Cutaneous Atrophy of the Extremities.**<sup>1</sup>—DR. BRONSON followed with a paper so entitled.

DR. SHERWELL said that the case had many features in common with a case produced at the last meeting of the New York Dermatological Society,

<sup>1</sup> Will be published.



but none of those present could clear up the conundrum which it involved. Some peculiar trophic and nutritive change is present.

DR. BRONSON said in closing that the case of Buchwald showed no new formations or enlargement in the blood-vessels whatever; any apparent increase may be accounted for by the translucent condition of the skin. If there was any enlargement it probably affected only the veins, which seemed unusually turgid; the loose and yielding character of the atrophied superposed skin caused them to become dilated through lack of normal support.

The only subjective symptoms were occasional shooting pains and sudden twitching.

**The Relation of Impetigo Hepetiformis to Pemphigus Vegetans.**—DR. ZEISLER, of Chicago, presented a paper with this title.

The features common to these two diseases are very striking. Both, too, occur mostly in women and begin upon a mucous membrane. The lips were first affected in a case reported. Deviations from the type must be considered possible, and a case should not be thrown out of either category because in some unimportant detail it does not correspond with the original description. For a positive diagnosis either disease must be observed carefully from beginning to end, which in both is a fatal one. Among the many points of similarity pointed out were the etiology and pathology, about both of which nothing is known. Vegetations are not always present from the outset, but appear where moisture, friction and warmth favor their development.

DR. HYDE said he was glad to do justice to the fact that Dr. Zeisler had seen his case long before he himself had seen the one he had recently described. The more he searched his mind the more he recalled points of resemblance between the two patients. Besides, the extension of the disease by miliary pustules and bullæ, there was also another mode of spreading by a peculiar undermining of the epidermis in the neighborhood of the patches. Besides the classical regions involved in this case there was also a necklace about the neck, and when the bullæ disappeared, a pigmented collar of dark hue was left on whose surface were minute lichenoid elevations and comedo-like points.

DR. ATKINSON: A number of the rare skin diseases have been shown to be closely related. I think in a number of the most rare diseases marked by profound modifications the dermal lesion is the expression of more important trophic influence; the lesion is the symptom.

My impression is that in Kaposi's cases of impetigo herpetiformis, those cases in which post-mortems were held led one to conclude that it was through some profound modification of the central nervous system that these symptoms were brought out, of which the cutaneous lesions were simply manifestations. We well know the common origin of diseases that have widely different ways of expressing themselves, and, conversely, the diverse origin of diseases that sometimes express themselves in similar manner.

DR. DUHRING thought Dr. Zeisler's view a just one. We must approach the subject from two standpoints: (1) The clinical, (2) the etiological and pathological. Concerning the second, in most cases these two diseases are very much alike, if not identical, and are due to a profound disturbance of nervous centers, the nature of which we are for the most part ignorant. We should distinguish and establish distinct types of these diseases, to

study the subject. We should take Kaposi's cases as typical of impetigo herpetiformis, and he should regard the case of Dr. Hyde as a typical representation of pemphigus vegetans.

We must insist upon having types of cutaneous diseases in order to make progress in the study of them.

In criticising Dr. Zeisler's observation he had desired to convey the idea that the cases were not in accord with Kaposi's definition ; he should prefer to classify them as unusual varieties rather than as types of the disease. He had no doubt that as our knowledge expands these diseases will be brought closer together. His present opinion is that while they are closely related, still clinically there is a difference. For instance, his own case of pemphigus vegetans would never be diagnosed by any one as impetigo herpetiformis.

DR. ZEISLER stated in conclusion that it never was his intention to obscure the distinction between these two diseases, but to call attention to cases which border upon both and to the difficulty of classifying each case.

**Protozoan Dermatitis.**—DR. GILCRIST, of Baltimore, by invitation, read an interesting paper with this title.

He related the first case of the kind recorded in this country. The protozoa were shown under the microscope. They were very numerous, sixty sometimes being in the field. Twenty had been found in one giant-cell. A dog had been inoculated, the same disease reproduced and protozoa being found. Dr. Gilcrist considered the bodies found as belonging to the vegetable rather than to the animal kingdom.

DR. DUHRING showed photographs of a case of generalized sarcoma sent by Dr. Breakey, of Ann Arbor.

DR. BRONSON presented a new dermal curette and comedo expressor.

The Association then adjourned to meet in Montreal, Canada, in September, 1895.

## GENERAL SESSION OF THE CONGRESS.

### UNDER THE DIRECTION OF

#### THE AMERICAN DERMATOLOGICAL ASSOCIATION.

**The Discussion on Leprosy.**—The first paper read was one by DR. HYDE of Chicago, entitled "The Distribution of Leprosy in North America."

After referring to the various ways in which the disease could effect an entrance into the United States, open as we are to it from every point of the compass, the speaker said the fact that leprosy had not spread extensively here was due rather to the excellence of our people's habits than to any wisely directed vigilance. Records are found of nearly six hundred cases having existed in this country, California furnishing 158, New York, 100 ; Louisiana 83, and Minnesota 120 of this number. He estimated that 100 lepers were now living within our borders, though at the present time California health authorities claim only about twenty-six for that State. Cases accumulate principally at points of commercial activity, and it is impossible to state the present number definitely. Its presence, however, offers a constant menace and a problem in sanitary science which the general government alone can readily solve. The question should receive intelligent discussion, and wise provision should be made for the leper's welfare and for public protection.

DR. WHITE of Boston followed with a paper on "The Contagiousness and Control of Leprosy."

The proof of contagiousness in a disease should be based upon, 1. The history of its action upon communities or nations. 2. The study of its action upon individuals. 3. Its resemblance to other affections generally regarded as contagious. 4. The establishment of a satisfactory cause for such contagion. 5. The influence of control upon its history and course. Speaking of the first point, leprosy was traced in its course through mediæval Europe. Heredity alone could not account for the spread which assumed such overwhelming proportions. To-day the extraordinary rapidity of the spread in the Hawaiian Islands and elsewhere can be accounted for in no other way than by infection. Turning to a study of the individual great difficulty is encountered because of the long period of incubation, two to ten years, rendering direct proof in the individual case almost impossible. Inoculation experiments, too, are out of the question, since animals do not respond and the possibility of acting upon human tissue in anything like a satisfactory manner cannot receive serious consideration. Reliance must be placed upon a careful study of beginning epidemics in small communities; instances in which immigrants from non-leprous into leprous countries contract the disease, and the development of leprosy among the attendants of those affected. The many points of strong resemblance between leprosy, syphilis and tuberculosis were pointed out as suggesting an intimate relationship in the etiology and pathology of these conditions. Discussing point four, which calls for a satisfactory explanation of the contagiousness, the speaker said the discovery by Hansen of the bacillus demonstrated the contagious nature of leprosy as clearly as had been shown that of tuberculosis when its bacillus was found. He regards the disease as pre-eminently bacillary.

Speaking of the influence which control had exerted upon the history and course of the disease, Dr. White said that in the later centuries after the disease had been controlled through segregation and confined to a few districts the belief grew that it was not contagious. A study of the disease in those countries where laws have been enforced for its control shows a great diminution in the number of cases, and where it has existed unchecked the number has increased. The theory of heredity is a dangerous one. The individual must be made responsible if the disease is to be exterminated.

So far as this country is concerned the following propositions for control were recommended:

1. Every physician should be compelled by State law to report to the nearest Board of Health the existence of a case of the disease, and neglect to do so on the part of the medical attendant, or a member of the leper's family, should be a penal offense.

2. Immigrants affected with the disease should be arrested at ports of entry and along our border, and turned back to their previous homes by the authority of the National Board of Health.

3. Graded hospitals should be established by the National Government, in insular localities, if possible, within which both suspected and confirmed cases should be confined, and to which all access should be prohibited, excepting under proper restrictions.

Such compulsory isolation may be considered cruel to the few, but its

longer neglect on our part is certainly a greater cruelty to the many, for in no other way shall we exterminate this most miserable disease.

Discussing this paper, Dr. Fox, of New York took the ground that while the disease was undoubtedly communicable the danger arising from contact or association with lepers was extremely slight. He said that whatever might be the result of inoculation-experiments he was sure that those who had given special attention to the study of leprosy would agree with him in this. In the United States the disease has never shown any tendency to spread among those brought in contact with communities of lepers. He thought that there was no necessity for the segregation of the lepers to be found in the United States. To forcibly take these individuals from their homes would be an injustice which the slight menace to the general health would not warrant. Syphilis and tuberculosis are much more liable to be communicated to others than is leprosy. Many cases of leprosy are amenable to treatment and capable of being cured, and he would be in favor of the establishment of hospitals for leprosy where these cases could be studied.

In the speaker's opinion the medical profession had done more harm than good in demanding stringent measures and in raising such a hue and cry over a stray case of the disease.

DR. BRYANT of New York strongly advocated active measures because such a course is humane so far as the leper is concerned; would be conducive to public security and confidence, and would secure good sanitation and better therapy. He offered the following propositions: (1) that a wise public policy and humane considerations demand that lepers be not permitted to associate with the unaffected; (2) that the exercise of local authority for their segregation is unwise and unsanitary, as establishing innumerable abiding places for the disease at great expense and without the assurance of proper surveillance; (3) that a safe, prudent, and humane policy demands that lepers be properly segregated under the care and control of the general government.

He estimated the number of lepers now in this country at 200, and depicted in a graphic manner the conditions which would prevail if we were to become stricken as Europe was in the eleventh century.

DR. WYMAN, Surgeon-General, U. S. Marine Hospital Service, spoke of the National Control of Leprosy. The laws already enacted have been in a measure effective. He thought it desirable that special places of confinement be established where any State might send these undesirable patients. It is incumbent upon the profession to leave nothing undone to exterminate this, together with other communicable diseases. Does the *right* of National control exist? If so how may it be best exercised? These questions were discussed from the two standpoints of National power granted by the Constitution and State power to make laws for itself. All obstacles could be overcome by one State establishing a hospital and being willing to receive lepers consigned to it by other States. If, however, the necessity could be shown, Congress could appropriate a sufficient sum for a National Hospital.

The outline of a bill covering the case was read. The disposition of the patients within a given State would still be left to the State. That Congress may be assured that the medical profession is not acting on insufficient premise it is suggested that a leprosy commission be appointed to report.



The speaker stated his own firm belief that leprosy should be under National control.

DR. VAN HARLINGEN, of Philadelphia, thought all physicians should study the disease more and familiarize themselves especially with its early manifestations. These are frequently overlooked and cases are too apt to pass unrecognized, and in spite of rigid quarantine many cases gained access to the country even after an examination. He had been informed that many Norwegians had come in with early signs of the disease which had escaped observation. He considered segregation the most important point in the treatment of the question.

DR. MORROW of New York presented a paper on "The Diagnostic Features and Treatment," which was read by title.

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#### THE NEW YORK DERMATOLOGICAL SOCIETY.

235TH REGULAR MEETING. HELD ON TUESDAY EVENING, MAY 22, 1894.

DR. C. W. ALLEN, *President, in the Chair.*

##### A Case for Diagnosis.—Presented by DR. S. SHERWELL.

The patient was a female, aged 42, married, a native of Austria. She had been of perfect health all her life. The lesions which she now presented first appeared on the backs of the hands about four years ago; later on they appeared on the anterior surfaces of the wrists, then around the toes and on the dorsal aspects of the feet, gradually extending up the legs and becoming very marked on the flexor surfaces just below the knee. About the same time they extended further up the arms on the flexor surfaces, to about three or four inches above the wrist, and then stopped. Small, pit-like atrophic depressions are seen on the backs of the hands; these atrophic cicatrices, as they may be called, have a peculiar bluish or lilac color by daylight, contrasting strongly with the brunette skin. On some of the other places affected later the atrophic change has not gone so far, but the same scar-like appearance on a plane with the skin exists, and they also in some degree have the same peculiar color. According to the history all of the lesions commenced as small itchy papules, very slightly raised above the surface of the skin; these became whiter, and gradually assumed the character of those now seen on the hands. There has been no disturbance in general health, except that she complained at intermittent times of an intense neuralgic pain in the left heel; this lasted for about eighteen months, and has not troubled her at all during the past year. Dr. Sherwell said the patient first came under his observation only a few days ago, and he had not been able to arrive at a satisfactory diagnosis. He could not recognize the disease as lichen planus, or morphea, or diabetic xanthoma, although in some features it resembled each of these affections, but was inclined to believe it as tropho-neurotic in character. He had never seen anything exactly similar before.

DR. FOX said that two or three weeks ago he saw a case very similar to the one presented by Dr. Sherwell. The lesions were partly papulo-pustular and chronic in character, and on the extensor surfaces of the arms there were numerous small, round cicatrices, similar to those in this case. The lesions

remained unaffected by specific treatment, and from their appearance and chronicity he regarded the case as one of pustular scrofuloderma, as described by Duhring some years ago.

DR. S. LUSTGARTEN said he did not think the history of this case coincided with that narrated by Dr. Fox. Dr. Sherwell's patient said that four years ago she had an acute eruption on the hands and feet, which, on healing, left these scars. While he had never seen anything exactly like it, he thought the lesions might belong to the class described by Kaposi as herpes zoster atypicus or hystericus. In such cases there was usually a history of hysteria, and areas of anæsthesia might be discovered. He expressed the opinion that the lesions in this case bore no resemblance to those of diabetic xanthoma.

DR. A. R. ROBINSON said the lesions were not at all like those seen in diabetic xanthoma.

DR. ROBINSON exhibited a *photograph* of a case somewhat resembling pityriasis rosea. The eruption was well marked, covering the trunk and extremities, and was rather similar in appearance in one case to a papular syphilide. He stated that five cases of this unique affection had come under his observation during the past month; in none of these were there any rings, and only slight scaling. The cases will be published.

DR. ROBINSON also exhibited a colored photograph showing a case of *lymphangioma circumscriptum*.

DR. ALLEN said that he now had under observation a case of pityriasis rosea, in which the eruption was somewhat similar to that shown in Dr. Robinson's photograph. His patient gave a history of having had a single itchy patch on the back, which was followed in about two weeks by a generalized eruption, covering the trunk, arms and legs, although the lesions were not as diffuse as those in Dr. Robinson's case. There was free scaling in some of the lesions.

DR. H. G. KLOTZ stated that Dr. Robinson's photograph reminded him of two cases coming under his observation during last Winter, in which an acute generalized eruption appeared, and lasted about a week or ten days. He regarded them as an unusual type of erythema; there was distinct scaling on some of the lesions.

DR. FOX said that during the past four or five years he has collected a series of photographs which showed different stages or gradations of eruptive processes from eczema to pityriasis rosea. Some of them might be regarded as acute psoriasis. There was one form of an acute, disseminated eruption which he had sometimes diagnosed as discoid eczema. In such cases the whole body usually became covered within a week or two with spots which at first might be hyperæmic and slightly elevated, and sometimes scaly. Some of these might assume an annular form, as in seborrhœal eczema. In other cases the spots were small, not very sharply circumscribed, simulating the lesions of psoriasis, especially as they occurred on the extensor surfaces of the extremities, and on the body. Dr. Fox expressed the opinion that eruptions of this character were on the border-line between eczema and psoriasis, and that their clinical appearance was as similar to one as to the other. In some cases the eruption would be most marked on the chest, and we might have a typical picture of pityriasis rosea. While it was well to maintain the names that have been applied to these various types of eruption, they were very similar in their clinical appearance, and prob-

ably also in their etiology. Dr. Fox said it has always appeared to him that they ought to be separated from the eczema which tends to exudation. The term discoid eczema was a very expressive one, as indicating a peculiar form of the eruption in which the lesions consisted of small, rather circumscribed discs.

DR. SHERWELL said that in cases where the lesions assumed the annular and circular form they would correspond with Gibert's disease, and should be so diagnosed.

**Three Cases of Lichen Planus in the Same Family.**—DR. LUSTGARTEN said that he had at present under observation a family in which the mother and two daughters were successively attacked with lichen planus in the course of the past four years. The mother, about four years ago, had a typical, rather severe, attack of the disease; she recovered under treatment, and now her body is entirely free from the eruption, with the exception of one indurated itchy patch on one thigh. About two years afterward the lady's daughter, who was married and had not lived with her mother for some years, had a mild attack of lichen planus. A few weeks ago a second daughter, aged 17, presented herself with a similar eruption. The people were living in very good circumstances and their relations were not specially intimate, not sleeping together nor using the same towel, etc. The family history was good. The women were of a rather nervous disposition, but well developed physically. In conclusion, Dr. Lustgarten said he regarded the occurrence of three cases of lichen planus in the same family as rather unique. So far as we know, the disease was considered neither contagious nor hereditary. The cases had been seen by a number of prominent dermatologists, who all had agreed on the diagnosis.

DR. KEYES said he had known two cases of lichen planus to occur in the same family. The patients were both young women, and one of them had a second attack of the disease. In that instance there was a family history of gout.

DR. ELLIOT said he saw no reason why we should claim that lichen planus was either contagious or hereditary. He looked upon Dr. Lustgarten's cases as a mere coincidence.

DR. PIFFARD said he had observed a number of cases of lichen planus in women occurring at about the time of the menopause. He did not know, however, whether that had anything to do with the appearance of the eruption. He had always been inclined to connect lichen planus with the gouty diathesis, although he has also observed it with the "hypercarbic" as well as with the "hyperazotic" diathesis.

DR. FOX said he had met with one instance in which two members of the same family were attacked with lichen planus. It was possible that the determining cause of lichen planus—whatever that may be—was transmitted from the mother to the offspring, and in that sense the disease was hereditary. The tendency or disposition to transmit the disease might be regarded as hereditary.

DR. SHERWELL said he agreed with the statements made by Dr. Piffard and Dr. Fox. He had a number of times observed the disease in persons with a gouty disposition and occurring about the time of the menopause, or any crisis. The patients were usually adults and well nourished, in his experience, with a tendency to lithiasis.

DR. LUSTGARTEN said the etiology of lichen planus was entirely problematical. It was probable, as suggested by Dr. Fox, that the disposition to the disease was transmitted.

DR. ELLIOT inquired as to what percentage of cases of lichen planus suffered from relapses. He had not met with a single case yet in which the patient gave the history of having had a previous attack, nor had he seen any in which a recurrence took place.

DR. ROBINSON said he now had a case under his care in which the patient had a similar attack five years ago; in the interim she was entirely free from any manifestations of the disease. He had also seen other cases in which the lesions disappeared for a time from one part of the body, and then reappeared elsewhere.

DR. TAYLOR said he had observed a number of cases of lichen planus in which recurrences took place; of sixty-nine cases collected by himself probably six or eight suffered from relapses. The relapses were not so persistent, and did not come at such short intervals as in psoriasis.

DR. FORDYCE referred to the case of a man, aged 30, who had two attacks of lichen planus. On each occasion the treatment of the disease by arsenic was followed by an attack of zoster.

DR. KLOTZ said that about a year ago he saw a case of lichen planus in which the lesions were principally confined to the legs and abdomen; since then the woman had a second attack, the same regions being affected.

DR. LUSTGARTEN said he had seen a number of cases in which relapses occurred. He was under the impression that insufficient arsenic treatment accounted to some extent for this occurrence.

**Comedones.**—DR. KLOTZ called attention to an affection of the sebaceous glands of the face, particularly of the nose, which, while by no means uncommon, he thought was not sufficiently well defined and described in the hand and text books. In the cases he had in view, on inspection, no indication of the presence of comedones could be seen, but on pressing or squeezing the nose white or yellowish plugs could be removed from numerous openings, consisting entirely of sebaceous matter. In one particular instance the patient had been a sufferer for several years of a periodical, benign, local erysipelas, returning about every two weeks during the colder season, never extending farther than over the nose and the adjoining portions of the cheeks. He was of the opinion that the ducts of the sebaceous glands were widely distended, and that the power of eliminating the sebaceous matter was destroyed by some atrophic process. He would be interested to hear what treatment would be considered effective. He had himself tried a number of remedies, including solut. Vlemineck's, without effect, and did not expect that drugs would produce any change in the condition. Where the number of the dilated gland ducts was a small one he considered electrolysis the only remedy.

DR. LUSTGARTEN expressed the opinion that in some of these cases there was present a parasitic chronic eczema of the nose, which often produced, first, hyperæmia, and, second, dilatation of the blood-vessels. With this hyperæmia there was a hyper-secretion of the sebaceous glands. The contents of the true comedones consisted largely of horny



matter, which was not the case in the instances mentioned by Dr. Klotz. As regards treatment, he advised resorcin ointment.

DR. FOX thought the name *seborrhœa sicca* would be applicable to this condition. We saw it sometimes without any apparent change in the nose, excepting, perhaps, slight hyperæmia, and by compressing the organ we might succeed in squeezing out a number of long threads of cheesy matter, thus reducing the swelling. The condition differed from the ordinary comedones, which were made up more particularly of epidermic scales, being purely sebaceous in character. As regards treatment, Dr. Fox advised daily massage, rubbing the nose and squeezing out the distended glands, and then the application of resorcin ointment.

DR. PIFFARD said that in a number of these cases coming under his observation rubbing and squeezing the nose daily, or so-called massage, made the condition distinctly worse. The organ increased in size instead of getting smaller. He thought perhaps the constant current would prove beneficial.

DR. ELLIOT said he agreed with Dr. Piffard. In a number of instances he had seen this condition greatly aggravated by massage, face steaming, etc. The more the organ was manipulated the worse the condition became. In its nature it was simply a hyper-activity in the secretory function of the fat glands, and a dilation of the follicular orifices resulted.

DR. ALLEN said he has had a number of patients under his care, especially women, in whom the widely dilated gland ducts on the face contained plugs of dirty sebaceous matter, producing more or less disfigurement, and in such cases treatment with the electrolytic needle proved very satisfactory.

DR. LUSTGARTEN said that this condition of the nose was sometimes the result of slight frost-bite.

**Report of Cases Presented at Previous Meeting.**—DR. FORDYCE announced that in his case of *nævus* of the lip, presented at the last meeting, the lesion had been reduced to one-half its size by means of punctures with the galvano-cautery at a dull red heat. The punctures thus made were not attended by any bleeding.

DR. KEYES said that in making the punctures in these cases he has always found it a good plan to insert the cautery along the periphery of the *nævus* in an oblique manner, so that the punctures converged at the center, thus cutting off the blood supply of the lesion.

DR. FOX said that in a case of a large *nævus* of the lip he injected carbolic acid, which produced a very bad slough.

DR. CUTLER reported by letter that the patient presented by him for diagnosis at the previous meeting—the Polish girl with lesions on the tip of the nose and on the palms—had markedly improved under anti-syphilitic treatment. The lesions, which had existed for about six months, had almost entirely disappeared.

DR. FORDYCE reported the case of arsenical poisoning as well.

DR. KLOTZ stated that since the last meeting he had seen two similar cases on men employed in a Paris green factory. He had taken pains to ascertain the kind of work done by the men and the way of exposure during the work. One of the men, who was rather intelligent, explained that they were engaged in stirring a fluid containing the Paris green, which was kept

boiling in large vats. They had to walk and stand around these vats, about high enough to reach to the knees, so that the ascending steam would readily come in contact with the scrotal region. The legs were protected by high boots.

DR. SHERWELL announced that his case of ichthyosis was in about the same condition as when last presented to the Society—perhaps slightly improved.

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## Book Review.

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*Gonorrhœa and its Complications.* By ERNEST FINGER. Third Edition. New York: William Wood & Co., 1894.

This is the translation of the third German edition of Finger's "Die Blenorrhœa der Sexualorgane." It is already too well known to the profession from the preceding editions to need a further introduction. The revision has been thorough, emendations and additions have been made to the text wherever more recent work on gonorrhœa has seemed to call for it, and it is now probably the most complete monograph on the subject in existence. The work of the translator (whose name does not appear) is up to the standard of the author's, and its appearance in English should be heartily welcomed. The volume is illustrated by seven good colored plates, and by numerous wood-cuts, chiefly depicting the forms of apparatus described.

The author admits no doubt now of the ætiological significance of Neisser's organism, and adds that it is universally accepted, save by a small group of French writers. He gives six conditions which must be fulfilled in order to establish the identity of the gonococcus, after an exhaustive review of the controversy waged over its diagnostic importance. The improved methods applied for its culture and the vexed question of mixed infections are considered at length in the light of late developments on these points. The chief changes, however, occur in the chapter on chronic urethritis, the bugbear and the reproach of the modern specialist in venereal diseases. This division has been largely rewritten, treatment being the point on which most stress is laid. The author does not permit marital intercourse until after two to four weeks' examination the clap shreds fail to show pus cells and when irrigated by the silver nitrate solution gonococci are not to be found in the secretion, in other words, absence of the diplococcus, pus corpuscles and peri-urethral complications. Satisfied of this, he permits marital intercourse.

The divisions of the monograph are acute, and chronic urethritis, complications in the male, blenorrhœa in the female, complications in the female and, finally, complications in both sexes. In the treatment of chronic spermatoecystitis no mention is made of the stripping by the finger through the rectum, or of the work done in this city. Finger draws an appalling picture of gonorrhœa in women and concludes that in them a latent disease may be as productive of disaster both to themselves and those with whom they practice coitus as a like condition in the male, and further, that the wives of men who suffered previously from gonorrhœa are usually sterile or bear only one child.

J. C. J.

# JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

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## Original Communications.

### A CASE OF SO-CALLED "ANGIOMA SERPIGINOSUM."

BY

JAMES C. WHITE, M.D., Boston,

Professor of Dermatology in Harvard University.

THE patient was a boy, 12 years old, of delicate appearance and highly nervous temperament. His mother furnishes the following history: At birth a "purplish red mark" was noticed below the right shoulder blade, semi-lunar in shape, with its curved edge directed upward. Its longest diameter was half an inch. It increased very slowly in size in an upward direction until he was four years old, when another spot no larger than the head of a pin appeared near the original one, which gradually became larger, and since then the others have continued to appear and grow up to the present time.

The affected area forms a belt about three inches in width, extending from the anterior edge of the right scapula six inches forward to the nipple, its upper margin being on a level with that point. (Fig. 1.) This region is occupied by some twenty-four individual lesions, varying in size from a pin's head to circular patches two or more inches in diameter. The process begins in the form of minute elevated points, of a bright red color, which slowly increase in size until they are an eighth to a sixth of an inch in diameter. At this stage they are elevated from an eighth to a twelfth of an inch above the general surface, are of a bright

red color, varying from scarlet to carmine, which can be made only partially to disappear by long pressure, and are of a firm consistence. Having attained this size they undergo involution at the centre, which slowly sinks down as the growth spreads peripherally. In this way rings are formed, and the disease progresses as an annular elevated margin, about one-eighth of an inch in breadth, slowly creeping outward, until by confluence with other lesions the regular circular shape is lost. This margin has the same characteristics as the original uniform



FIG. 1.

"ANGIOMA SERPIGINOSUM." BLACK LINE POINTS TO FIRST EXCISION. X INDICATES THE PORTION EXAMINED.

patch, in color, elevation and consistence. Within the ring the skin has apparently returned to its natural condition excepting in color, which remains of a dull purplish or dusky hue. New foci, in the shape of minute points, appear at some little distance from the older areas, and assume in time the same annular mode of progression with central involution. Only a very few minute points are to be observed springing up anew in the old central depressed areas.

In October, 1892, an attempt was made by Dr. H. W. New-



hall of Lynn to destroy the anterior group of lesions, some seven or eight in number, by the Paquelin cautery. The operation was apparently successful for a time, for pale cicatricial tissue took the place of the former rings and smaller circular patches, which has remained without change, but the growth has gradually crept beyond these scars at every point at their borders, and assumed its original condition.

We find, therefore, the following striking appearances upon the regions thus treated: numerous small, circular, smooth, white scars, slightly depressed, surrounded by a narrow, elevated ring, of a bright red color, and one large patch of irregularly oval form, two inches in its longest diameter, its central portion of a dull purplish color, the old untreated area of involution. Around this a belt, a quarter inch in width, of pale scar tissue, and outside of this a narrow, elevated, carmine rim of new development.

All the affected portions of the skin are sensitive on slight pressure, so that the patient shrinks from the touch of the observer, but he is of an excessively "nervous" temperament. The parts also itch frequently. There is no turgescence of the tissue.

There is no record of any angiomatous conditions in earlier generations.

Now what is the nature of this remarkable affection? Apparently an angioma, which, beginning as a minute papule, like the well-known "cayenne-pepper dots," slowly increases to the size of a pea, and then undergoes spontaneous involution in its central portion, while it spreads outward in annular form to an indefinite extent and for an indefinite period, so that after ten years circinate areas one or two inches in diameter are formed. The elevated margin, or ring, preserves a uniform breadth about its whole circumference, as though the process had a self-limited period of activity or existence, just as the life history of the vegetable growth, or the fertility of the epidermal soil in *tinea circinata* determines the breadth and duration of the ring as it progresses outward. New foci are continually developing some distance, one-eighth to one-third of an inch, beyond these older areas, which in turn are converted by central involution into the annular forms. The tissue in all stages of activity, the small papules and the rings in all their parts, present the same character—a firm, smooth, elevated structure, varying from a bright red to a claret color. The central areas after involution sink down to the normal level, but remain stained of a dull purplish-brown tint.

Mr. Hutchinson was the first to call attention to the remarkable peculiarities of this affection in his Archives of Surgery in 1891, and gave it the title—infective angioma or *nævus lupus*. He has published also a brief account of three other cases, one observed by Lassar and called by him *lupus erythematosus*, one by Tay, and another by Jamieson in Great Britain. The four cases differ from one another in some respects, but the characteristic features, the progression in annular form and the development of the “satellites,” as Hutchinson calls them, outside of the rings, were present in all of them. He seems to regard the process as in some way allied to his *lupus lymphaticus*, which is *lymphangioma*, but this view may be considered problematical. The seat of the disease in these cases was respectively: the upper extremity, the arm and lateral thorax, the face and upper extremity, and the lower extremities. Three of them began before the age of two. In one of them only was there positive evidence of the existence of a previous *nævus*. In none of them, it should be noticed, has any form of ulceration or malignant transformation been observed at last record. Crocker gives a description of the disease in his last edition, founded upon the above cases, under the title *angioma serpiginosum*, which seems to me to be a more appropriate one than that of Mr. Hutchinson.

That an angiomatous, or *nævus*-like growth should invade new portions of the cutaneous tissues in this manner, progressing in a serpiginous or annular form, while undergoing uniform involution in the areas first infected, and at the same time to be developing new foci beyond its original seat, has seemed to me a process so novel and inexplicable that only the most careful study of its histology could reveal the nature of its mysterious pathology. At my request, therefore, Dr. Newhall very kindly removed one of the smaller lesions, which was just assuming the annular form. One portion of this was sent to Dr. Darier, the distinguished chef du laboratoire de la Faculté a l'Hôpital Saint Louis, Paris; the other was given to Prof. W. T. Councilman of the Medical School of Harvard University, both of whom have made a most careful study of the specimen. Dr. Bowen had also examined a specimen removed some months previously.

Dr. Darier's report follows:

(Translation) The piece of skin which I have examined was sent to me in alcohol. In its preparation I have completed the hardening by the action of alcohol and gum. The sections

made perpendicular to the surface have been submitted to various coloring reagents, and mounted partly in glycerine and partly in Dammar resin.

Examination by a low power shows, toward the middle of the sections, a lesion occupying the whole extent of the derma, and consisting of a mass of cells deeply colored by the reagents. These masses are more or less sharply defined at their borders, and present very diverse outlines, circular or ovoid, with festooned or angular margins, or drawn out into trails, which, in the sufficiently thick sections, seem to form, by ramification or anastomosis, a coarse network. In places where the section shows much of these cell-trails it can be seen that they occupy about a quarter or a third of it.

It is desirable to specify the relations which these masses of cells bear to the normal elements of the skin.

The epidermis is composed of its ordinary layers unaltered, and is not infiltrated by the numerous migratory cells, as occurs in inflammations.

The papillæ appear to be a little elongated and enlarged in the middle portion of the specimen, but the cell masses have nowhere penetrated into their interior.

These masses are, on the other hand, numerous in the sub-papillary layer, where they form in places a nearly continuous layer. In the corium proper one sees sometimes ovoid masses, sometimes streaks running parallel to the fibres, or ascending to ramify themselves on reaching the more superficial layers. Finally, in the deeper layer of the corium, upon the border of the hypoderm, where the sweat-glands lie, the masses of cells are abundant and large and are often seen in immediate contact with the glomerulus. Sometimes they penetrate it and the cells separate the loops of the glandular ball, but in spite of such intimate relations the tubes of the gland are always easily recognized, and are never invaded or destroyed. An elongated mass of the cells may often be seen accompanying the sweat canal for some distance. The other glandular structures of the skin and the muscles are healthy. The arterial and venous vessels of the hypoderm are normal. Those of the corium are all included and, as it were, drowned in the elongated masses of cells, and are to be recognized with difficulty or altered, as I will describe below.

In fact, the elongated streaks of cells are arranged along the course of the vessels, following them in their distribution,

and stretching themselves out in sheets about the glomeruli and especially on a level with the sub-papillary plexus.

The cutaneous tissues between the cell masses are scarcely or at all altered. In the papillæ the cells are, perhaps, a little more numerous than natural. There is no modification in the fibres and cells of the corium. The border of a mass may be seen at some points to connect with a capillary network surrounded by some cells. The sections colored by orcein, according to the method of Tänzer-Unna, with the nuclei colored by methylin-blue, show the elastic network perfectly preserved, and not even interrupted or broken by the elongated cell masses, which only insinuate themselves between its meshes.

It remains to carefully study the new-found cell masses to determine their nature. With high powers applied to sections colored by hæmatoxylin, methylin-blue, picro-carmin, or alum-carmin, it may be seen that the elements of which they are composed are cells, having, for the most part, a fusiform, aplastic, or angular shape. Their protoplasm is abundant, and the nucleus is generally oval in form. They present the characteristics of young connective-tissue cells, and bear the strongest resemblance to such cells of the neighboring interfascicular spaces.

This is manifestly no question of epithelial cells, but of cells having a mesodermic origin. Nor are they any more migratory cells or leucocytes, although there are in their midst sometimes an uncertain number of elements of the latter kind, recognizable by their smaller size and diminutive nucleus, and by being more deeply colored and often bosselated, but they are in great minority. This fact furnishes conclusive evidence that we have not to do with a subacute inflammatory lesion of perivascular seat, as one might think on superficial examination. The persistence of the elastic tissue, which disappears, as a rule, in contact with inflammatory foci, and the absence of migratory cells in the intermediary tissues and epidermis, are additional arguments in the same direction. (I have seen upon the borders of young tumors of the mycosis fungoide of Alibert and Bazin young elements of an analogous appearance and distribution, but in such a case the elements are nearly all round cells identical with leucocytes.)

Moreover, a careful examination of a fine section permits certain details to be recognized, which are of great importance. In all the masses the flattened cells have an evident tendency to group themselves concentrically about a certain number of



centres. Such a centre is very often made up of two or three cells of the same nature attached at their edges and forming thus a canal. Sometimes the opening of the canal is very small and empty, sometimes it contains one or more leucocytes, or even granules, which appear to be the débris of blood globules (altered by alcohol). At two or three points I have seen the centre occupied by a cell much larger than the others with several nuclei (a vasoformative cell?).

It appears, then, that we are dealing with a new formation of capillaries at the expense of the elements of the neoplastic tissue. These capillaries are sometimes perfect, sometimes abortive, and on the other hand sometimes dilated to a considerable degree. One finds, in fact, vascular cavities circumscribed by a single row of flat cells, and presenting the dimensions of an enormous arteriole. By the side of capillaries cut transversely there were others where the section had been made obliquely or longitudinally. The dilated vascular cavities are generally empty, but in some of them more or less altered red globules were observed. A certain number of these dilated capillaries are to be observed in the sub-papillary layer of the corium.

How, then, is this lesion to be classed, and what name shall be given it?

A neoformation, non-inflammatory, composed of cells of the type of young connective-tissue cells, ought necessarily to bear the name of *sarcoma*. But it will be observed that we are in the presence of an unusual form of sarcoma, not massed in a single tumor, but reticulated and infiltrated as a network, which appears to follow the normal distribution of the vessels of the skin. There is, moreover, to be noticed the tendency which the cells of this sarcoma have to form networks and clusters of more or less dilated capillaries, that is to say, to transform themselves into a true *angioma*. The epithet, angioplasmic or vasoformative, would express this peculiarity.

I will conclude by proposing for this new formation the title: *sarcome angioplastique réticulé*.

I have never seen hitherto a case which completely resembles this one clinically and anatomically, but I have seen and studied many ordinary angioplasmic sarcomas. I should remark, moreover, that it is very common to find in certain naevi, those designated as *verrues charnues* (*verruca mollis*), cell products very analogous to those of this case. One may find, for instance, in the corium, elongated masses of cells, having the

appearance of sarcomatous or endothelial cells, which have at times in their centre an empty space so well marked that it is a question of a new-formed capillary. Some parts may be distinctly sarcomatous—at other times the cells of the neoplasm are pigmented.

The benign congenital sarcomas (for which one has proposed the name of endotheliomas improperly, seeing that endothelial cells are of the same nature as ordinary connective-tissue cells) may, under some unknown influence, give rise to invading sarcomatous tumors, and even to a generalization of simple, melanotic, or telangiectasic sarcoma.

The information which I have received, that this tumor started upon the surface of a nævus, leads me to think that it is a case of this sort, that is, a *nævus à structure de sarcome angioplastique devenu envahissant*.

Here follows the report of the examination made conjointly by Prof. Councilman and Dr. Bowen:

“Two portions of tissue taken at different times from lesions presenting the same characteristics were investigated, one of these somewhat larger than the other. Both were hardened in absolute alcohol, stained in various media, cut in serial sections and examined. The various methods of staining did not bring out any especial differences in the histological details. The stainings which gave the best results were a combination of hæmatoxylin and eosine, and safranine. For the investigation for bacteria sections were stained in Weigert’s fibrine stain, with and without a counterstain in carmine. The epidermis and the epithelial appendages of the epidermis, such as hair follicles and sweat-glands, present no alteration. (Fig. 2.)

The inter-cellular tissue of the papillary layer and of the corium generally is unaltered. The special pathological condition consists in groups of cells distributed in the corium. In general these cell groups are fairly well circumscribed. They vary in size, and their general arrangement is parallel to the surface of the skin, although there are numerous exceptions to this. The groups are rarely round, but have a longitudinal shape, frequently extending in long masses, which sometimes appear to be formed from amalgamations of neighboring groups. Along with the perfectly definite cell groups there are other places which show a more or less circumscribed increase of cells, which have generally the same longitudinal arrangement as the definite groups. Few of these extend up

into the papillary layer. In general the number of cells in the papillary layer is not increased, although here and there rows of cells are seen. In this layer the rows of cells generally have a direction perpendicular to the surface. Examined with a high power the cell groups show a considerable degree of difference. This concerns not only the number but the character of the cells in different groups and in different parts of the same group. The nuclei have a general direction parallel to the course of the mass. They stain brightly with all of the staining

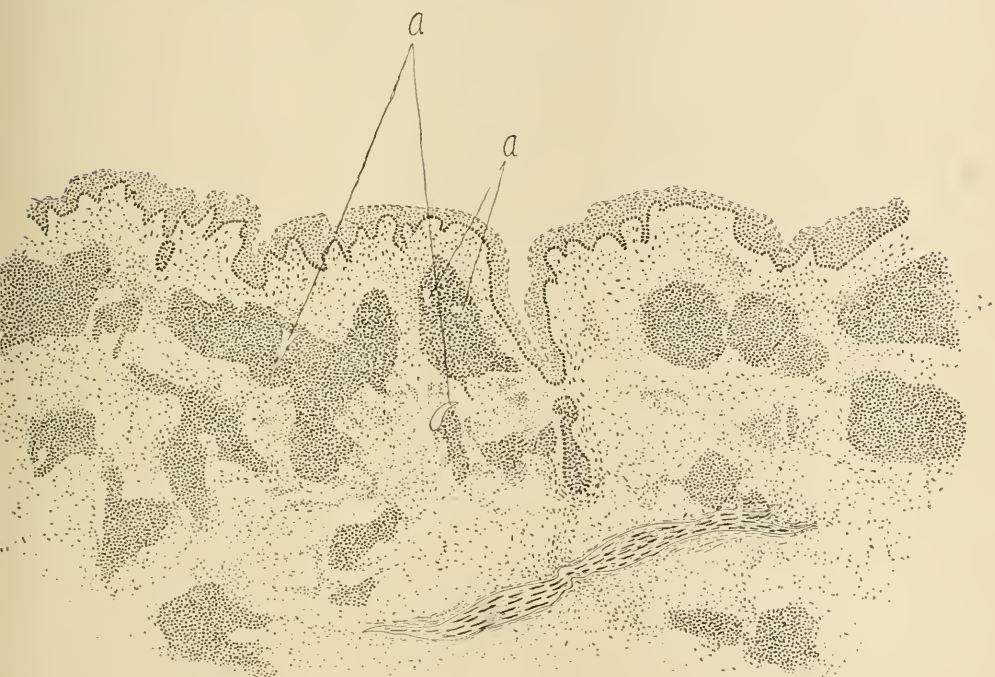


FIG. 2.

"ANGIOMA SERPIGINOSUM." SHOWING CELL GROUPS IN THE CORIUM. a a DILATED LYMPHATICS IN CELL GROUPS X 60.

reagents used. They are large, oval in form, and have something of the appearance of the nuclei of epithelioid cells. They are surrounded by a small amount of protoplasm, and the individual cell boundaries cannot always be distinctly made out. In all of the groups of cells, without exception, an arrangement into smaller groups or clumps is apparent. This is more definite at the periphery of the nodule than in the interior, al-

though even in the interior it is appreciable. In the periphery there are frequently closely packed groups of cells, often showing a formation around a lumen, with rows of cells around this concentric to the inner group. (Fig. 3.) Between these masses of cells there are long fusiform nuclei, also showing the group arrangement and possibly to be referred to longitudinal section of the cell groups. In some parts of the group the cells cease abruptly, in others they extend various distances into the surrounding tissue. In the vicinity of the nodules and frequently at a distance from them, various changes in the vessels can be made out. The changes consist in swelling and proliferation of the endothelial cells of the vessel, frequently combined with proliferation of the cells on the outside, so that two rows of cells can be distinctly recognized. These vascular changes apparently affect small veins and capillaries. No lesions were found in any of the arteries which could be recognized as such by the presence of a muscular coat. Most of the cells are of the same general character. Here and there a few smaller cells corresponding to the small round cells of granulation tissue are evident and there are a few poly-nuclear leucocytes. There is no evidence whatever of anything corresponding to inflammation. The vessels of the cell groups are anæmic rather than turgid, and there is no general leucocytic infiltration. A marked peculiarity of the process consists in the presence of small granular masses here and there in the cell groups. Some of these, corresponding to the course of the section, are round, others longitudinal. In the hæmatoxylin and eosine stain they are colored more brightly with eosine than the rest of the section. They are not sharply circumscribed, they are granular and show no definite structure. In some of them portions apparently more solid than the remainder are seen. In sections which cut these structures longitudinally they are long, irregular, and frequently have pointed ends. Here and there in the centers of the cell clumps a number of cells can be seen more granular and not staining so brightly as the surrounding cells, and every gradation between this and total necrosis of the cells can be made out. These structures are rather more common in the smaller groups of cells where the nuclei have a more distinctly longitudinal arrangement, corresponding rather to cicatricial tissue. In some of the sections, notably in those first examined, the cell groups are frequently arranged around spaces and fissures in the skin, evidently corresponding to lymphatics. Where this is the



case, the nuclei of the space appear to be swollen and slightly increased in number. Here and there in the surrounding tissue blood-vessels, usually small veins and capillaries, show a considerable degree of dilatation. These dilated vessels generally show no other pathological condition. The bundles of non-striated muscular fibre are prominent and possibly some-



FIG. 3.

"ANGIOMA SERPIGINOSUM." (a) FROM MARGIN OF ONE OF THE LARGE CELL GROUPS, SHOWING ARRANGEMENT OF CELLS IN CONCENTRIC CLUMPS.

(b) VESSEL FROM MARGIN SHOWING MASS OF DEGENERATED CELLS.

(c) VESSEL IN VICINITY OF CELL GROUP, SHOWING PROLIFERATION OF ENDOTHELIUM.

what increased in thickness. No connection of the process with the cutaneous nerves could be made out. Staining with the appropriate reagents revealed a considerable number of plasma cells within the affected area. It could not be seen that they were more numerous in and about the cell groups than in the tissue of the corium generally, although they were

certainly more numerous in the area occupied by the lesion than in the adjacent normal tissue.

When we regard the process as a whole, it would seem evident that it is one intimately connected with the vessels of the skin, affecting certain groups of vessels. This is shown both by the arrangement of the cells in the groups, and by the general course and position of the groups. The groups frequently appear in the neighborhood of dilated lymphatics, but the process is one affecting the blood-vessels rather than the lymphatics. It would seem to begin by a proliferation of the endothelium of the vessels accompanied by a corresponding proliferation of the perithelium. The single small masses of cells in the groups with concentric arrangement of the cells around them admit of no other interpretation. The central clumps of cells show every phase of degeneration and the granular masses are evidently to be referred to necrosis and coalescence of these cells. The fact that this degeneration is chiefly seen when the cells are few in number and when the process is evidently of older date seems to show that with the advance of the cell proliferation in the vessels there are at the same time degenerative processes going on, leading to the destruction of the vessels and the cessation of the circulation. No complete new formation of blood-vessels is apparent. Where the cells are thickest the process shows a certain degree of activity, which can be judged by the presence of nuclear figures. From a purely histological consideration of the growth it may be compared to an angio-sarcoma, it being understood that with this name only the histological appearance is taken into consideration. The cause is possibly to be referred to that underlying tumor formation in general, it being due to some anomalous congenital condition of the vessels. There is nothing in the histological characters which would lead us to regard it as in any way analogous to the infectious tumors.

In conclusion, we wish briefly to call attention to the histological appearances found in congenital as well as in acquired pigment spots of the skin by Demiéville (*Virchow's Archiv.*, 1880), and since confirmed by other observers. "Nests and strands" of cells are found in the corium, produced by cellular infiltration of the adventitia of the blood-vessels, and the vessels exhibit also a constant proliferation of their endothelial cells. Ziegler refers to these nests and strands of epithelioid cells as occurring in a variety of cutaneous formations, which

are mostly congenital or developed in the earliest years. To these formations he gives the name cellular nævi. While the lesions that we have been describing present peculiarities not seen in those hitherto reported, the points of resemblance are sufficiently striking to warrant the conclusion that in certain respects this case offers an analogy histologically with the congenital and acquired pigment spots, as first studied by Demiéville."

A comparison of these two reports, made independently after prolonged and most careful study by such eminent experts in France and America, is of great interest. They differ in no essential respects so far as relates to the actual changes in the cutaneous tissues, although they do not entirely agree in their interpretation of the same. They coincide in recognizing that the growth is made up in the main of masses of endothelial cells. Darier emphasizes the constructive nature of the process in pointing out the agency these cells take in the formation of new blood-vessels, whereas Councilman and Bowen call attention to the degenerative character of the process going on in the vessels, and recognize only a proliferation of the perithelial and endothelial cells of the vessels. The latter state that the growth may be compared histologically to an angio sarcoma, whereas Darier calls it unreservedly a sarcomatous neoformation, an angioplastic sarcoma.

Other and better known types of sarcoma associated with telangiectasis, such as the case reported to this Association by Dr. Hardaway in 1882, have been observed to undergo involution in their central areas, and to progress in an annular form—and this is true also of some pigmented varieties. In our case no extravasated or modified blood pigment was observed, although no examination of the older and stained central portions was made.

Accepting, then, the relation of the case to sarcoma as established by the investigations of these accomplished pathologists, whether it be that of a close resemblance only on the one hand, or of absolute identity on the other, it is evident that the prognosis must be unfavorable, and that the probable development of some eventual malignant transformation in the nature of the process should not be disregarded.

It is to be hoped that this thorough study of the anatomy of our American case of this rare disease may lead to a similar investigation of the English and German cases, as reported

by Hutchinson and Crocker, so that we may know if all five of them, which bear so close a resemblance to each other in their clinical features are really identical. In the meanwhile the title suggested by Darier is certainly more appropriate to the case I have presented to you.

In conclusion I desire to record my sincere thanks to the distinguished pathologists who have given me such important assistance, and who have contributed to this report its chief value in discovering the true nature of so rare an affection.

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### URETHRITIS POSTERIOR AND THE DIAGNOSTIC VALUE OF THE MODIFIED THOMPSON TEST.<sup>1</sup>

BY

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**I**S posterior urethritis a complication of gonorrhœa or a frequent physiopathological condition; and does the so-called cut-off muscle really separate the anterior from the posterior urethra so thoroughly that it is an insuperable barrier to the rearward progress of the disease in its normal course?

These questions have been the subject of so much controversy in recent medical literature, and are so familiar to all that I shall detain you but a very little while with their discussion.

It is due to the influence of the French school that for years it has been the standard belief that gonorrhœa in its typical course goes as far as the bulbous urethra. Posterior urethritis was believed to occur very rarely before the third or fourth week; an affection of this region before the third week was thought to be due to either internal constitutional causes, as : syphilis, tuberculosis, gouty or rheumatic disposition, or to external mechanical factors, as riding, dancing, early treatment, excess *in baccho* or *venere*.

This appears to be the generally held opinion of most authors in this country at the present time.

In Morrow's System of Genito-Urinary Diseases, in the article by Brewer, we read: "Of all the *complications* (italics mine) which arise in a case of acute gonorrhœa, posterior urethritis is by far the most frequent. Unless caused by direct

<sup>1</sup> Read before the Section on Genito-Urinary Surgery of the Academy of Medicine.



infection as the result of the passage of instruments, it rarely appears before the third week."

So much about urethritis posterior acuta.

In a paper of Lydston "Remarks on Chronic Urethritis"<sup>1</sup> the author says: "A word as to the frequency of posterior urethritis as a sequela of gonorrhœa. I do not think it is so frequent as it is usually believed," and to prove this assertion he continues: "Pray consider what proportion of our patients has vesical symptoms or epididymitis in the course of gonorrhœa. I say vesical symptoms for the sake of clinical distinction. The trouble is rarely vesical, but the symptoms are decidedly so. The proportion of such cases is decidedly small. If such symptoms (*i. e.*, vesicular and testicular) have been absent throughout I infer that the posterior urethra has not been invaded, at least to the extent of a primarily acute infection. If such symptoms have been present I infer that posterior inflammation has not only occurred, but is still present in greater or less degree.

"For diagnostic purposes urine drawn in two glasses is sufficiently accurate. If the second glass be clear, I do not think we should waste much time worrying over the posterior urethra."

I am of the opinion that most of you do not share these rather radical views, which are fallacious and based upon unstable and erroneous conclusions.

We all know that the gonococcus penetrates the deeper tissues of the mucous membrane at an early stage of the gonorrhœa. It has been proven that the propagation is not only one *per continuitatem*, but—and that seems to be the more common way—through the lymph channels.

Therefore the theory that the cut-off muscle—although it forms anatomically and physiologically a sharp border between the two parts of the urethra—should prevent the gonorrhœa from spreading into the membranous part is untenable.

Finger has claimed that the gonorrhœa stops in front of the pars membranacea because the latter is sparsely supplied with follicles and lacunæ, and is less vascularized than the penile urethra, in a similar manner as sycosis, for instance, stops at the border of the hairs where there are no follicles. A plausible theory, but a mere theory at best.

In looking over the literature I have not been able to find any statistics upon which those who claim that urethritis pos-

<sup>1</sup> JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, April, 1894.

terior is a complication of gonorrhœa have based their opinions; so that the conclusion seems to be justified that this belief is a dogmatic one.

In a paper read before the German Medical Society of this city, on December 7, 1891,<sup>1</sup> I have said: "Through the communications of Letzel, Rona and Heisler, and through their statistics my attention was drawn to the frequent occurrence of urethritis posterior, and I have convinced myself that urethritis posterior is to be observed on the tenth or twelfth day in primary cases, even where the patients had not injected or had been exposed to external influences."

Since then a number of very valuable contributions on that question have appeared, of which I only mention those of Jaddassohn, Eraud and Rona. The latter has shown that of 200 patients who had never had any urethral trouble before, and in whom the gonorrhœa was not over two months old, the following was found:

Of 47 patients who were observed in the						
			first week	37	had urethritis totalis	= 83%
" 74	"	"	second "	64	"	= 87%
" 30	"	"	third "	29	"	= 97%
" 49	"	"	fourth to eighth weeks	48	"	= 98%

In none of these cases had a sound or any other instrument been used. Only three of the 180 patients who had a urethritis posterior had constitutional disturbances, and in nearly all of the cases an injurious effect of the occupation or excess *in baccho et venere* could be excluded. It is interesting to note that of 39 patients who presented themselves with a urethritis posterior in the first week after infection, only one had been treated internally, the balance had had no treatment at all; of 64 in the second week 11 had had injections, 3 internal treatment, 50 no treatment.

On the other hand, of the 13 patients who had urethritis anterior only 9 had used injections, and yet they had no affection of the posterior urethra.

I ask your pardon for having taken up so much of your valuable time with a review of Rona's paper. I have done so because his observations impress me as exceedingly accurate and conclusive, and because the paper itself is not sufficiently known, probably because it was published in the *Hungarian Archive of Medicine*. The results which I have obtained in the examination of a similar number of cases in different stages of

<sup>1</sup> *New Yorker Medic. Monatsschrift*, January, 1892.

gonorrhœa are very much like those of Rona, although the percentage of urethritis posterior is not quite as large in my cases as in his. I will refer to my results in the course of this paper.

For the present allow me to speak of the means which we have for the diagnosis of posterior urethritis.

You all are familiar with the variety of means at our disposal in arriving at a diagnosis in affections of the urethra, but we are not entirely at liberty to use them whenever and wherever we would like to. We require, for instance, a positive indication for the use of the endoscope, and must be assured that our patient is not exposed to any harm or danger by being subjected to an endoscopic examination. A careful physician, be he ever so firm a believer in and warm advocate of the endoscope, will only use this or any other instrument after the more simple diagnostic aids had been resorted to. A diagnostic aid which is practical, painless and reliable is the examination of the urine.

Subjective symptoms are of importance when they are present; but they are often misleading, nervous patients with urethritis anterior often showing subjective symptoms suggestive of urethritis posterior, or rather of cystitis colli. On the other hand, it is a mistaken idea that patients with urethritis posterior always complain of or have frequent micturition. I have paid particular attention to that question, and have found this symptom wanting in a great many cases where the examination of the urine showed conclusively that the posterior urethra was affected.

What is the diagnostic value of the analysis of the urine?

If the urine is simply voided into two glasses (Thompson's test) it is of very limited value. I have demonstrated<sup>1</sup> the fallacies of the conclusion that if the urine in the second glass is clear and free of filaments the urethra posterior is not affected, and that in its original form the Thompson test does not possess the diagnostic value which has been claimed for it. The method which I recommend, viz., to precede the urination by an irrigation of the anterior urethra until the latter is free of pus and filaments, has been used by the writer for the last seven years. It has been generally accepted in Europe mainly through the efforts of Jadassohn, and found to be reliable, safe and easy of execution. In this country the diagnostic value of this modification is not sufficiently appreciated, and the method is not practiced often enough.

<sup>1</sup> *Medical Record*, December, 1888.

When I described the method it was entirely unknown to me that the same modification of the Thompson test had been proposed by Aubert and Eraud. They had simply mentioned it in a few words in a French journal which probably the fewest of us know of. This may excuse my oversight to give credit to whom it was due, and may explain the fact that their proposition did not find universal recognition, not even in their own country.

The irrigation, as I now practice it, is done by means of a short hard rubber or glass tube which is attached to the irrigator. This tube is introduced up to the fossa navicularis or further and withdrawn a short distance; this manœuvre slightly distends the urethra at the time; the meatus is, however, not kept closed. The manipulation can be easily carried out in a few minutes so that it may even be employed in dispensary practice. The irrigation not being painful, can safely be practiced in acute cases; but I admit that in gonorrhœa of a few days' duration it is not absolutely necessary to irrigate the urethra for diagnostic purposes. Here the simple Thompson test will be sufficient, provided that the patient has not urinated for 3 to 4 hours.

The conclusions which we can draw from an examination of the urine following the irrigation, do not need to be discussed to-night; I will simply mention that if there be cloudiness of the urine, bacteriuria, phosphaturia, and carbonaturia have to be thought of.

It is advisable to let the patient pass his urine into two glasses, then examine prostate and seminal vesicles per rectum, after which procedure the patient voids the balance of his urine in as many glasses as necessary.

This modified Thompson's test was considered an accurate test until Lohnstein, of Berlin, in a paper "On the diagnosis of urethritis posterior,"<sup>1</sup> subjected the "Goldenberg-Jadassohn modification," to a severe but just criticism, concluding that this method is not free from faults and practically not as perfect as had been claimed by the authors.

The modification, as you all know, is based upon the presumption that the *musculus compressor urethræ* prevents the liquid which is used for irrigation from entering the posterior urethra. If, however, that is not the case, Lohnstein properly argues, the products of inflammation in the anterior urethra will enter the posterior urethra together with the liquid which is employed for cleansing.

<sup>1</sup> *Deutsche medicin. Wochenschrift*, No. 44, 1893.



That there is such a possibility, the author concludes, is proved by the successful efforts of Rotter, Rona and others to fill the bladder from the urethra without the use of a catheter.

In order to prove that the irrigating liquid and eventually filaments may enter the posterior urethra, Lohnstein employed the following method: For the irrigation of the urethra he used a  $\frac{1}{2}$  per cent. solution of ferrocyanide of potassium, which together with chloride of iron gives the "Prussian blue" reaction. The test is so sensitive that if only a few drops of the ferrocyanide solution enter the posterior urethra the urine will give the reaction, at least the first portion of urine. Lohnstein irrigated the anterior urethra until the solution of ferrocyanide came out clear and free of filaments. He then washed out the penile urethra with water until the latter did not show the Prussian blue reaction on adding chloride of iron ( $\text{Fe}_2 \text{Cl}_6$ ). This assured him of the fact that there was none of the ferrocyanide left in the anterior urethra. The patient then urinated. Absence of filaments in the urine shows that the posterior urethra is not affected. The first portion giving the Prussian blue reaction demonstrates that during the irrigation the m. compressor has relaxed and that the ferrocyanide solution and possibly filaments have entered the posterior urethra. Altogether there are the following possibilities:

First, the urine is clear, free of filaments; color remains yellow on adding  $\text{Fe}_2 \text{Cl}_6$ .

Second, the urine is clear but assumes blue color on adding  $\text{Fe}_2 \text{Cl}_6$ .

Third, the urine is cloudy or shows filaments but no Prussian blue reaction.

Fourth, the urine is cloudy or shows filaments and Prussian blue reaction.

The first three possibilities give us a univocal answer; the fourth one does not enable us to decide if the filaments have entered the posterior urethra from the anterior through the irrigation, or if they have been formed in the posterior urethra. The decision must be left *in suspensio* until "a repetition of the test has cleared up the matter."

Of ninety-four cases of Lohnstein the urine assumed the blue color thirty-seven times, thus indicating that in about forty per cent. of the patients, the modified Thompson test gave evidence of a urethritis posterior where there was none.

I am well aware of the fact that irrigation of the bladder is possible without the use of a catheter, a procedure, by the way, which is by no means new, having been described by Zeissl in 1874.<sup>1</sup>

These irrigations of which, as a therapeutic method I do not approve, are practiced with closed meatus, the pressure being sufficiently steady and strong and the patient in a position so that the *vis a tergo* is reduced *ad minimum*.

I did not, however, expect that in the ordinary irrigation with the reservoir at a height of about  $1\frac{1}{2}$  metres and the meatus not closed, any liquid would enter the posterior urethra. Therefore Lohnstein's figures rather surprised me; his paper, however, impressed me so favorably that I did not lose any time in following his method.

The first series of my cases comprised thirty-five patients in whom the irrigation was performed with a "reflux catheter" 12-14 Char. The routine of Lohnstein was strictly adhered to, viz.: irrigation with ferrocyanide, flushing with water until there was no reaction on adding Tinct. ferri chloridi. The urine voided after the irrigation did not give the Prussian blue reaction in any of the thirty-five patients, of whom sixteen had an acute, nineteen a chronic gonorrhœa.

Having abandoned the employment of catheters in practicing diagnostic irrigation of the urethra, my second series comprise sixty-five cases in which the canal was flushed by means of the short glass tube connected with an irrigating jar, as described before. The result as to the reaction was the same as in the first series. In not a single case did the urine assume a blue color on adding  $\text{Fe}_2 \text{Cl}_6$ .

The difference between my results, an account of which has been published before,<sup>2</sup> and those of Lohnstein, was too striking to be considered accidental. In his ninety-four cases the reaction occurred thirty-seven times while I, in 100 cases, did not observe it once. I claim that on my part and on the part of the gentlemen who assisted me in dispensary practice every precaution was used. The reaction being such a sensitive one, I considered it necessary besides flushing the penile urethra thoroughly with water to cleanse likewise the glans penis and the preputial sac. On the other hand it is far from my desire to impute any faults to Lohnstein in his experiments. He

<sup>1</sup> Vierteljahresschrift für Dermatologie.

<sup>2</sup> "Ueber den diagnostischen Werth der Zweiglaesserprobe," Centralblatt für die Krankh. der Harn und Sexualorgane, Band V., Heft VII.

does not give any detailed description as to the manner in which the irrigations were made, and fails to state what degree of pressure was resorted to; he simply mentions that he irrigated "by means of a Nélaton catheter."

For comparison sake I employed a Nélaton for irrigations in thirty-one patients. The size of the catheter varied between 15 and 18 F., according to the size of the meatus, the height of the irrigator being about  $1\frac{1}{2}$  metres above the penis.

In eleven of those thirty-one cases the urine actually showed the Prussian blue reaction on adding  $\text{Fe}_2 \text{Cl}_6$ , proving that in employing Lohnstein's method of irrigating the *musculus compressor* had relaxed in eleven cases and that the modified Thompson test showed itself faulty in about thirty per cent. of the cases.

It is interesting to state that in those very same eleven cases no reaction was noted when the irrigation of the anterior urethra was made without the use of a catheter, but with the glass tube, as mentioned before.

This fact clearly proves that it is not the method which is faulty, but the manner of its execution. It is not difficult to explain why in using a catheter the Thompson test with irrigation shows itself somewhat unreliable. The mucous membrane contracts about the eye of the instrument; the liquid forms a whirl directed toward the bladder, its reflux is obstructed and the m. compressor relaxes so that part of the liquid which is used for irrigation enters the posterior urethra and eventually the bladder.

That the flushing of the anterior urethra without the use of a catheter is sufficient to cleanse it of the products of inflammation was demonstrated by first irrigating the canal without and then with a catheter on the same subject, at the same sitting and at the same height of the irrigator. It was found that when the irrigation with the catheter was continued until the liquid came out clear the subsequent cleansing with the catheter did not reveal any filaments in the fluid which was collected in a glass.

From the foregoing experience, based upon an analysis of one hundred cases, I consider the modified Thompson test a faultless and practical means of demonstrating which part of the urethra is affected, a method which can be easily carried out, without any inconvenience to the patient.

A few more words about the frequency of urethritis posterior. My material, taken from private and dispensary prac-

tice, analyzed for the purpose of determining how frequent the posterior part of the canal is affected, comprises so far one hundred and ninety-five cases of gonorrhœa in all stages. As I am continuing these researches I will not detain you to-night with a detailed analysis, but shall simply review these results in a few words.

Of the one hundred and ninety-five cases of which I have kept a record, one hundred were examined after Lohnstein's method. They are the cases which were used for testing Lohnstein's irrigation with ferrocyanide of potassium. In the other ninety-five cases the urine was examined after cleansing the anterior urethra with boric solution or with water.

The posterior urethra was found to be affected in one hundred and sixty-two patients, that is, in eighty-three per cent. of all cases.

Of the patients who presented themselves in the first week of the infection thirty per cent. manifested urethritis posterior.

Of those who came under observation in the beginning and first half of the second week forty per cent. had urethritis posterior.

In those who claimed that their gonorrhœa was from 12 to 21 days old the posterior urethra was found to be affected in seventy-five per cent.; in gonorrhœas of four week's duration and more, in eighty-five per cent. of all cases.

As to the duration of the gonorrhœic infection we are naturally dependent upon the statements of the patients, the fewest of whom are such close observers that they could accurately state when the disease actually began. The figures therefore are not absolutely binding as to the time.

In each one of the cases a note was made if the patient had had any treatment before he applied to me and what the treatment consisted of. Most of the acute cases had not been treated before and yet a posterior urethritis was found, in some of them, as early as 5 to 6 days after the first symptom showed itself. It was furthermore particularly noted that most of the patients who presented themselves with epididymitis had had no local treatment or only internal treatment.

The conclusions which I beg to submit are :

*First*, Urethritis posterior is no *complication* of gonorrhœa but a *physiopathological extension* which is to be found in eighty to eighty-five per cent. of all cases.

*Second*, An affection of the posterior urethra before the



third week is not caused by instrumental or therapeutic manipulations, or dyscrasias. It is, as Rona says, "the natural outcome of the progressive nature of blenorrhœa which spreads as long as the soil is favorable for propagation."

*22 East Sixty-third Street.*

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#### GOUTY DEPOSITS OF THE TESTICLE.<sup>1</sup>

BY

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THE rarity of this condition is my excuse for offering it to your worthy consideration, and I shall ask your indulgence but for a very short time, on account of the almost entire lack of literature upon this subject and therefore my inability to offer you anything except what I have myself derived from three cases of tophi, or chalk stones, in the testes.

In my use of the word testicle, I wish you to understand it in the general sense and including not only the gland itself, but also the epididymis, the cord and its coverings, and the testicular tuniçæ, with the exception of the scrotum. The word chalk stone is an extremely erroneous one, as a gouty tophus is not composed of chalk, that is, calcium carbonate, but is mainly made up of crystals of the urate of sodium. Eichorst in his excellent article on gout gives an illustration of these crystals removed from a tophus of an ear cartilage of an old case of gout. Loomis in his *Practice of Medicine* says that gout may be misplaced or metastatic, where it has retroceded to an internal organ, and that there is not a single organ in the body but what may be so affected. Mondat in his work on sterility, in the fifth edition, published in 1844, gives as one of the causes of sterility in the male ossification of the testes, and recites a case which must have been due to gout and not to real ossification. Lawford Knaggs, of London, in the *British Medical Journal* of May, 1891, writes under an article called "Cases Illustrating the Surgical Relations of Gout," of a case of epididymitis which came on without any apparent cause in a patient of a gouty diathesis. The urine was loaded with crystals of oxalates and the hyalin casts, but no albumen. There were no urethral strictures or vesical calculi. It seems

<sup>1</sup> Read before the Wisconsin Medical Society, May, 1894.

in this case that there was only an inflammatory condition and not any form of deposit. Lyman in enumerating symptoms and complications of gout, says that epididymitis and obstinate forms of urethritis, are very common in arthritic subjects, as are also herpes præputialis and very early frontal baldness. Keyes says that a low grade of true orchitis located in the fibrous covering of the organ is liable to attack gouty individuals. John P. Bryson, in an article on tumors of the testicles, writes of calcareous deposits, but only as following fibro-cystic and cartilaginous growths as a degeneration, not mentioning it, however, as being of gouty origin.

The following cases exhibit a remarkable number of the peculiar symptoms that people of gouty diatheses have, and do not fail in any single one of the following diagnostic signs to show their coalition. Hereditary tendency, sex, mode of living, condition of urine, florid complexion and apparent appearance of good health, early frontal baldness, return of attacks, uric acid in the blood to a large extent in two cases and in the other one it was found in hydrocele fluid in about the same proportion; character of paroxysm and presence of deposits in two of the cases at least in other parts of the body besides the testicles. The situation of these deposits is apparently not limited to any particular part, except that possibly the tunicae, which are of connective tissue of a strongly fibrous variety, contain the most of them, as gouty deposits are prone to show a solicitude for fibrous tissue. The portions of the testicle which contain them have lost their testicular feel, are nodular and when the point of a needle is put against them it grates, and there is no sign of pain elicited from the patient after the needle has passed through scrotal tissues. I have excluded all other diseases for the following reasons: The patients have gout; no history of venereal disease that has any connection with the testicles. According to Fournier hereditary syphilitic sarcocoele has been but once reported in the epididymis and that was in a very young child showing very many other syphilitic lesions. Syphilis usually exhibits itself as a diffuse orchitis and results in a fibrous degeneration with later atrophy of the testicle. Fibrous deposits in the testicle, with calcareous deposits after gonorrhœa, are not possible, as there is every reason to believe that there was never venereal disease in these cases, and in one of them I have watched the development of the deposits and they commenced immediately after the first attack of gout. In two of the cases there is history of

injury to the parts; in one a fall and in the other a kick; and it is often seen that a joint that has previously been injured is the site of gouty deposits if the patient is of a gouty diathesis. The rapidity of formation without systemic effects, absence of glandular growths in vicinity, variety of pain, etc., are quite sufficient to eliminate carcinomata and sarcomata; according to Moullin, if a tumor of the testicle has lasted more than six months without the doubt clearing up as to what it is, it is certainly not malignant. Translucency by electric light eliminates cystic sarcocele. Perhaps it will seem rather presumptuous to try to give reasons why these cases should occur in just the way they have, and I trust I may be pardoned in so doing when I offer the excuse that they are at least unique and sententious. As predisposing causes in these three cases we have in one a young man newly married indulging to an extreme degree in the gratification of his passions, naturally causing a great deal of hyperæmia of the parts, in another a direct inguinal hernia from a fall when a child, that becomes easily unreduced and not well held in place by the truss worn; in the third one a varicocele without support.

Now as to what it is that directly produces these deposits: The blood normally contains no uric acid, and in gout it often contains as high as 25-100 of one per cent. Firstly, the genital organs are better supplied with blood than any other part of the body and owing to their pendent condition cannot get rid of the venous blood, particularly where there is any extra barrier, as explained in these cases, nearly as quickly as they should. Secondly, fibrous tissue on account of its non-vascularity and sluggish circulation is the tissue that is the recipient of these deposits. Thirdly, in gout the urine is scanty and irritating. It scalds the tissue over which it passes, a urethritis being a common accompanying condition.

As regards prognosis there is little to say, and that is all conjecture. When the deposits become extensive sterility must be a very probable outcome. Suppuration might occur, as in calcareous degeneration, and leave fistulæ. Ultimate recovery depends upon future gouty attacks, in respect to general symptoms and deposition of more tophi, but as regards the present deposits prognosis is unfavorable for their removal.

Treatment is limited to general dietetic measures and the prevention of more growths and the enlargement of those present; removal surgically if the size or pain inconveniences. There have lately been some suggestions made upon the use of

electricity in connection with the removal of gouty tophi but in regard to that I have nothing to report, as it has not been tried on any of these cases.

*Case I.* Mr. S., age 28, blonde, weight 145, height 5 feet 6 inches. In April, 1893, a young man of German parentage consulted me for gastritis and exhibited to me a stony growth in his right testicle which seemed to be in the covering of the epididymis in the globus minor. There was also a left varicocele. He gave history of several attacks of rheumatism, as he called it, and said his father's knuckles were enlarged and had the same stones in them. The growth was noticed three years prior to his visit to me and followed an attack of rheumatism which occurred shortly after he was kicked in the perineum. The usual diet in this case was largely nitrogenous, and he drank a great deal of beer. His rheumatism has left deposits in the small joints in the hands. He has suffered much from tonsillitis and nose-bleed. There have since occurred deposits in the right cord and left tunica albuginea testes and globus major. There is frequently herpes progenitalis, and at present (April) the patient has an acute attack of both right and left epididymitis without history or symptoms of any venereal disease whatever. Three weeks ago removed for experimental purposes by mechanical leech from back about 20 grammes of blood and examined the serum by the Garrod test for uric acid and got a large number of crystals. This test is so simple that I might here mention it. Take 5 grms. of blood serum or fluid from hydrocele and add 5 decigrams of acetic acid; place a few hairs or threads in the mixture and set aside in a dark cool place for from 24 to 48 hours, and if there is an excess of uric acid, *i. e.*, .17 to .25 of one per cent., there will be crystals on the threads at the end of that time. This is the only case of the three where there is any doubt about the disease being gout, and the presence of the uric acid in such large amount proves it conclusively.

*Case II.* Mr. N., age 24, blonde, healthy, ruddy complexion, weight 190, height 5 feet 8 inches. Fifteen months ago was called to see this young man just married, with the following history: Since the age of 20 had lived a very fast life, traveled a great deal, drank largely of wines and beers, particularly champagnes. Father aged 66, gout every year since 20 years of age, and treats by baths every year at Kissingen. De-



nied all venereal disease and shows no signs of same. Food has always consisted largely of meats, particularly of game when in season. Had kept late hours and had been out much in bad weather. At this my first visit he recited a pitiful story of his experience the night before. The metatarso-phalangeal joint of the right large toe was swollen, hot, red and painful to the touch, but the greatest distress was in the right testicle, which appeared hard and enlarged as in a gonorrhœal epididymitis. This attack lasted about ten days, when he was again around and I had the opportunity of examining the testicles without causing him pain, and found that there was a hydrocele forming on the left side which continued to fill up until the first of August of last year. I tapped it and also again every ten days for four times, hoping every time would be the last; so in September I injected a gramme of carbolic acid after washing the cavity out with cocaine solution, which operation cured the left hydrocele. Soon after this the right one began to form the same, but that needed but one tapping. It was done in January of this year and has remained so without any reappearance. There are now deposits in the right and left epididymis and testicular coverings and in right cord. They are not painful and the needle scratches them and gives a sound to the ear. In other parts of the body there are deposits of the left metacarpo-phalangeal joint of the first finger, in right wrist, left ankle and gastrocnemius, the latter being about five by three by two centimeters in size, hard and painless to the touch. One of the photographs, shown at the meeting reveals the protuberance of the testicles so far in fact that the penis seems but an inch in length. The weight of these deposits necessitates the wearing of a suspensory bandage.

*Case III.* Mr. H., weight 180, age 35, height 5 feet 7 inches, blonde, healthy looking young German. Father dead some years. Had attacks of gout every Fall. Came to me about a year ago showing, as in photograph, a growth in the left testicle which forces the penis over on to the right side. Has had several attacks of gout, in one of which I attended him. This deposit gives all the appearances as in Case II. and leads me to believe it to be a case of gouty deposit.

110 *Mason street.*

## A CASE OF DIPHThERITIC VULVITIS IN A CHILD.

BY

A. L. GNICHTEL, M.D.

THE patient, a girl, aged 1 year, first came under observation on September 11, 1894. The mother stated that about five days previously the child had become irritable and restless, and showed other signs of pain, which were referred to the genital region ; these symptoms were aggravated during micturition.

An examination of the vulva revealed several patches of false membrane covering anteriorly the internal portion of both labia majora and nymphæ, and invading the urethral orifice. The membrane was firmly attached and grayish-white in color. The mother stated that two fatal cases of diphtheria had recently occurred in the house in which she resided, the last one about one week before her child was taken ill. There were no throat symptoms. A bacteriological examination made by Dr. William H. Park revealed the presence of the diphtheritic bacilli.

The patches disappeared under the use of local applications—chiefly peroxide of hydrogen and bichloride of mercury—and the child made a good recovery. At no time while the patient was under observation were any marked constitutional symptoms noted.

437 West Forty-fourth Street.

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## Society Transactions.

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## THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY. STATED MEETING, HELD ON  
TUESDAY EVENING, OCTOBER 9, 1894.

DR. R. W. TAYLOR *in the Chair*.

**Report of two Cases of Vesical Neurosis.**—By DR. GEORGE E. BREWER.

The first case was that of an unmarried woman, aged fifty years, who first came under the speaker's observation two years ago. From early childhood she had shown evidences of a highly developed nervous system. Her general health was fair ; never robust. She subsequently studied medicine and soon afterward had an attack of so-called cystitis, with painful and frequent micturition. These symptoms continued for a year or more, and were accompanied by several attacks of grave digestive disturbance. Acting upon the advice of her physician, she gave up her practice and made her residence in the country, where her general health improved and for

several years she was comparatively free from trouble. She then returned to the city, where she had frequent attacks of bladder trouble. About two years ago, when Dr. Brewer first saw her, she complained of painful and frequent micturition ; she was obliged to urinate about every hour during the day, and ten or fifteen times at night. The urine was found to be normal in amount, clear, light amber in color and highly acid ; the specific gravity was high ; it was free from bile, albumin and sugar. The patient was put to bed and placed on a milk diet, but there was no relief. She was then given acetate of potassium until the urine became neutral or alkaline ; this made the symptoms worse and was discontinued. There were no evidences of an inflammatory condition of either the bladder or urethra, although the latter was very sensitive. The uterus and its appendages were found to be normal. The bladder symptoms gradually became more aggravated, and morphine suppositories were required to quiet the pain. These produced such a derangement of digestion that they were discontinued. Bromide of soda gave her some relief, but it was not tolerated by the stomach. Anything which affected her general health aggravated the vesical symptoms. Dr. Brewer said he then lost sight of the patient until a few days ago, when he learned that the woman's bladder had been opened by a gynecologist in this city, and that no lesion of the organ had been found, excepting slight thickening of its walls.

The second case reported was that of a man, aged thirty-eight years, unmarried. In 1888 he had an attack of gout and symptoms of neurasthenia. He visited Carlsbad and was well for three years. About this time he had a mild attack of gonorrhœa, and one year later an attack of cystitis. This continued for two or three months, and was accompanied by great prostration. In March, 1894, there was a recurrence of his vesical symptoms, with marked nervousness and depression, and almost complete insomnia. On April 15th, when Dr. Brewer first saw him, the patient complained of frequent micturition, and a constant pain in the hypogastric and perineal regions. He also suffered from constipation, anorexia and headache. The temperature and pulse were normal. The urine was diminished in amount ; it contained neither bile nor albumin. There was a slight stricture in the anterior urethra. An examination of the bladder proved negative. The man was given large doses of acetate of potassium, and advised to drink water freely. This resulted in a temporary improvement, but after one or two sleepless nights his symptoms returned. It was then determined to make a careful examination under æther. The patient was anæsthetized with great difficulty, a cystoscopic examination of the bladder was made and the seminal vesicles examined. With the exception of a stricture in the anterior urethra, which was divided, nothing abnormal was found. After the operation the man gradually sank into a condition of semi-coma, and this was followed by a period of mental exaltation, which continued for about ten days, when he recovered his ordinary mental state. Early in June his vesical symptoms became so severe that he was compelled to remain in bed for six or seven weeks. He also had attacks which he described as follows : while sitting or lying quietly, he would suddenly become aware of a rapid failure of strength ; he would then pass a large quantity of perfectly clear, colorless urine. These attacks occurred about once or twice weekly. Since September 1st his strength has gradually returned ; his mental condition is normal ; appetite excellent ; nutrition good.

His attacks of bladder irritation occur less frequently now than formerly and are not so severe in character.

In concluding his paper, Dr. Brewer expressed the opinion that in both of these cases the vesical symptoms were of nervous origin.

DR. F. TILDEN BROWN inquired whether in the first case reported there was any possibility of the patient having been a masturbator. He recently saw a very similar case, the patient being a female, aged about fifty, who admitted being a confirmed masturbator. In another case which has been under his observation for the past eighteen months, the patient complained of frequent and painful micturition, for which no adequate cause could be found. As it was thought likely that the vesical symptoms were due to the presence of a stone in the ureter or kidney, the patient was put on piperazine, which resulted in the discharge of a large quantity of uric acid crystals. After this attack of gravel she complained of numbness in the foot, and had an ataxic gait. The bladder symptoms have disappeared, but the patient still has an ataxic gait, and Dr. M. Allen Starr, who saw her several times, is of the opinion that she had an attack of transverse myelitis. It is possible. Dr. Brown said that some of these cases of bladder trouble are due to a lesion of the cord which does not progress beyond a certain point.

DR. EUGENE FULLER expressed the opinion that in the first case reported by Dr. Brewer the vesical symptoms were of neurotic origin. Not infrequently, in these cases, where the patient is a woman, an unfortunate love affair, or an unhappy marriage is at the bottom of her trouble, and if we can change the current of such a patient's thoughts, and keep her mind off herself, her general condition will improve. The second case reported by the author Dr. Fuller thought would eventually prove to be one of locomotor ataxia.

DR. B. E. VAUGHAN narrated the history of a case coming under his observation in which the patient, a neurasthenic, had pronounced vesical symptoms for which no adequate local lesion could be discovered.

DR. R. W. TAYLOR said that in the first case reported by Dr. Brewer there might possibly have been a pericystitis.

**A Case of Gonorrhœa Aborted by the use of Silver Nitrate.—By DR. F. TILDEN BROWN.**

Male, æt. 39; U. S., single. The patient's personal history was negative with exception that nine years previously he had an attack of gonorrhœa, complicated by bilateral epididymitis and stricture, for which he had been operated on. The history of his present attack is as follows: He exposed himself to infection on June 25, 1894; four or five days later a diagnosis of gonorrhœa was made by his physician; this was confirmed by Dr. Brown on July 2d, gonococci being found in the urethral discharge. At the patient's earnest request, it was decided to make an attempt to abort the attack. The patient lying prone, a short speculum (Brown's) was introduced, and the urethra moderately distended. There was considerable congestion, especially anteriorly. The canal was cleansed with a three per cent. solution of peroxide of hydrogen, and then a six per cent. solution of nitrate of silver was applied and the speculum slowly withdrawn. Following this treatment there was considerable swelling and discomfort, and a little blood was passed on micturition. The next day the discharge was very



slight, and the man was given an injection composed of zinc, lead and hydrastis. There was no discharge on the three following days. On July 7th one gonococcus was found in the urinary sediment. After this there was no further discharge, and repeated microscopical examinations proved negative.

DR. BREWER said that while the treatment of gonorrhœa in its early stage by means of strong solutions of silver nitrate seems perfectly rational, it has never proved very successful in his hands. A number of writers have reported cases successfully aborted by this method, and it is certainly worthy of trial.

DR. FULLER agreed with Dr. Brewer. The possible bad effects of the treatment should be told the patient beforehand.

DR. H. G. KLOTZ referred to a paper read by von Sehlen before the German Dermatological Congress recently held in Vienna, in which he recommends irrigating the urethra with mild solutions of silver nitrate (1-1,000) and gradually increasing the strength up to one or two per cent. Dr. Klotz said he tried this method in two cases, and no bad results followed. He considered it preferable to the application of more concentrated solutions.

DR. VAUGHAN stated that he has tried the abortive method of treatment in three cases, injecting a ten per cent. solution of silver nitrate. In one of the cases it proved successful, while in the other two the discharge returned after four or five days, and both of these cases were complicated by epididymitis.

DR. TAYLOR said that in undertaking to abort a case of gonorrhœa, the severity of the attack must be taken into consideration. In some cases the gonococci are much more numerous than others. The receptivity of the patient is another factor; some urethræ are much more vulnerable than others, and offer a more favorable nidus for the propagation of the gonococci.

DR. BROWN, in closing the discussion, stated that in a very severe case of gonorrhœa, abortive treatment undertaken three or four days after the onset of the attack, as it was in this case, would prove futile. Even if undertaken on the first day of a very violent attack of specific urethritis it would probably not be successful in more than fifty per cent. of the cases. In applying the treatment it is well to distend the urethra, thus gaining access to the crypts and ducts of the glands. The preliminary use of peroxide of hydrogen is also of value as a cleansing measure.

#### **A Case of Ulcer of the Bladder.—By DR. BANGS and DR. VAUGHAN.**

This patient, who was presented by Dr. Vaughan, was a male; æt. twenty-eight years; unmarried. Denies venereal disease. In September, 1893, he began to complain of headache, chills and fever, and two days after that he had pain and scalding on urination. Since then he has been growing worse. Sometimes he is obliged to urinate every half hour. No blood. The man was admitted to the Post-Graduate Hospital on February 13, 1894. An examination revealed a stricture of 22 F, which was cut internally and the deep urethra dilated. After this his bladder was irrigated regularly with boric acid solution, and also with silver nitrate solution, 1-1,000; the local treatment seemed to make him worse. His temperature ranged from 99 to 101; appetite poor. The urine contained pus; other-

wise it was negative. No tubercle bacilli were found upon repeated examinations. Cystoscopic examination made on April 3 showed an ulcer distinctly outlined at the base of the bladder, about one inch from the neck. On the following day a solution of silver nitrate, one dram to the ounce, was injected into the bladder, and then neutralized with salt solution. The pain following this was slight, and on the following day an improvement in the man's condition was noticed. The patient was then put on cod liver oil and hypophosphites. On April 10th the cystoscope showed the ulcer in stage of healing. Several more injections of the silver nitrate solution were given, and on April 24th the man was discharged from the hospital very much improved. On May 1st an examination of the urine was made by Fraser, who reported finding three tubercle bacilli in twelve preparations. On July 9th the patient suddenly had a very severe hæmorrhage from the bladder. He was put to bed, ergot was given internally, and the bladder irrigated with creolin solution. Temperature and pulse normal. On the 22d he had a chill and his temperature went up to 103. The bladder was then irrigated with bichloride of mercury solution, 1-40,000. From this time on the patient continued to improve. A cystoscopic examination made on August 1st simply showed a congestion of the mucous membrane of the bladder. The man was discharged on August 14th; he can now hold his urine three or four hours during the day, and sometimes is not obliged to get up at all during the night. He is steadily gaining flesh and has been able to resume his work as a coachman.

DR. FULLER said that in his experience, cases of tuberculosis of the bladder are aggravated rather than benefitted by applications of silver nitrate. Guyon and others have also observed these disastrous effects, and now employ bichloride solutions instead.

DR. BROWN referred to a case of tuberculosis of the bladder reported to the Section last Winter, by Dr. S. Alexander, in which the effects of the silver nitrate applications were exceptionally good.

DR. TAYLOR expressed the opinion that the evidence upon which the diagnosis had been based in this case was rather slim. Repeated microscopical examinations revealed the presence of only three tubercle bacilli, and from these no cultures had been made.

DR. J. P. TUTTLE said that in cases of tuberculosis of the bladder he has noticed that the patients do not have a regular daily elevation of temperature; for a week or two they may not have any constitutional disturbance; then they have a chill or chilly sensations followed by high temperature and by an increased discharge of pus. Where the temperature is continuous there is more apt to be a simple inflammatory or ulcerative condition.

DR. BROWN said the fact that only three tubercle bacilli were found does not weaken the diagnosis. He has seen several cases of tuberculosis of the bladder with quite severe subjective symptoms where for months the tubercle bacilli were sought for in vain.

DR. VAUGHAN, in closing the discussion, said that the clinical symptoms in this case all pointed toward the presence of a tuberculous lesion. As regards the use of silver nitrate he agreed with Dr. Fuller that in these cases it usually does more harm than good. In this patient the solution of 1-1,000 aggravated the man's symptoms, while the solution of one dram to the ounce, applied to the lesion direct, and then neutralized with salt solution, proved beneficial.

**A Case of Hydronephrosis from Obstruction of the Ureter; Nephrotomy; Prolonged Drainage of the Kidney.**—This patient was presented by DR. VAUGHAN for DR. BANGS. He was a male; æt. 46 years; married; Irish; carpenter; family history good. Thirty years ago he had an attack of severe pain in the left hypochondrium, with vomiting; no purging. There was tenderness on pressure; no tumor was noted, nor was there any disturbance of urination. This attack lasted one week. Since then the man has had several attacks similar in character to the foregoing. In the Fall of 1891, after such an attack, the man noticed a swelling in the abdominal region. On examination a mass was found occupying the left half of the abdomen, extending upward to the ribs, and downward to the groin, where its shape was fusiform. The percussion note over this swelling was flat; there was a feeble but distinct fluid wave. The tumor did not change with the movements of the body. There was no varicocele nor œdema of the extremities. On November 19th the mass was aspirated, and a thin dark fluid withdrawn; this did not have the odor of urine. An examination of the urine gave the following result: specific gravity, 1022; a trace of albumin; pus, hyaline casts. On November 27th an operation was undertaken. The usual lumbar incision for nephrotomy was made, and on examination it was found that the mass was continuous above with the capsule of the left kidney and below with the ureter. With the finger an irregular sac wall was made out, with bands crossing here and there. No stone was found. More than two pints of fluid were withdrawn from the sac, and a large drainage tube inserted. A solution of methyl blue injected into the sac reappears in the urine. The patient was discharged from the hospital on January 23, 1892. There has been a gradual improvement in his condition, and he is able to attend to his work. The man is still wearing a drainage tube, its outer end being connected with a urinal bottle. In reply to a question, Dr. Vaughan said the obstruction in the ureter was probably a calculus, although none was found during the operation.

**Specimen Showing Ulcers of the Bladder.**<sup>1</sup>—Exhibited by Dr. B. E. VAUGHAN.

## Correspondence.

### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

**Researches upon Cutaneous Absorption.**—In a recent communication made by Dr. Renaud to the *Société Thérapeutique* he recalled the but little known experiments made by Dr. Roussin more than thirty years ago upon this subject. This distinguished savant demonstrated that the human subject placed in a hot or cold bath absorbs nothing, neither the water nor the salts dissolved in it so long as the body is emersed; but that he absorbs rapidly the salts deposited upon the surface in a pulverized state as soon as the water has evaporated.

The author has taken up the experiments of his predecessor, and can only confirm the result he had obtained. When one takes a bath containing 200 to 500 grams of iodide of potassium and care is taken on coming out of the bath to bathe the surface carefully with tepid water before dressing,

<sup>1</sup> Will be published.

we can not find the least trace of iodine in the urine or in the expectoration during the succeeding twenty-four hours. When, on the contrary, one does not wash after coming out of the bath and dresses without drying the body analysis shows the presence of iodine in the urine, and in the expectoration. It is equally found when a solution of iodide of potassium is applied with a brush upon different portions of the body and left in place until complete evaporation, or when the body is rubbed with the iodide reduced to a fine powder. The author has been enabled to cut short attacks of intermittent fever in infants by rubbing the body with quinine dissolved in a small quantity of water.

Everyone knows that the skin absorbs medicinal agents incorporated in ointments made with lard or oil; that is to say, with substances which can mix with the fat from the glands of the skin; on the contrary, when one is in a cold bath or a hot bath it is impossible to wet the skin which is constantly covered with a protecting coat of fat, so there is no fear of absorption.

**The Employment of Optical Methods in the Clinical Study of Cutaneous Eruptions.**—Dr. Broca has just made a series of researches of a very interesting nature on the optical conditions which can favor the observation of eruptions. Since the healthy skin and eruptive spots diffuse the same quantity of red light we must attempt to eliminate the red rays, which only serve to impede the observation. We succeed in eliminating them either by examining a photographic plate taken from the subject, since the photographic plate is not sensitive to red rays, or in examining the skin through a blue glass. To employ the blue glass we make use of a binocle of blue colored glass, since binocular vision is necessary, and we must furthermore protect the eyes laterally with both hands placed like the blinders of a bridle. It is necessary, in a word, that the eyes receive only the light which traverses the blue glass. In looking in this way and in being careful not to fix the gaze upon any one particular point, but to let the regard wander, we may often see spots appear and disappear. This results from the fact that the sensitiveness is not the same in all the varied points of the retina. When the image of one point, presenting a very slight eruption, is made upon a very sensitive point, it is perceived, then the movement of the eye containing the image is displaced, and a point less sensitive is impressed thus, it is no longer perceived, and so on. These fugitive perceptions correspond, then, to an objective reality and not to a subjective phenomenon. The observer should have the eye as much at rest as possible. It is well to put on the blue binocle and to protect the eyes with the hands without making pressure so as to avoid phosphenes before beginning the observation.

Artificial light is usually very unfavorable for those observations of delicate perception, but we must make exception for the light of the electric arc which is very rich in blue and violet radiation. Observations should not be made in a room furnished in red. Blue tints, on the other hand, are favorable for examination with the naked eye. When one looks at a patient with blue glasses the room should be always well lighted with daylight. Dr. Broca thinks that with photography and the use of blue glasses we can succeed, 1, in making out an eruption before the unaided eye reveals it; 2, in finding, again, traces of a preceding eruption; 3, in re-



vealing the existence of a concealed eruption ; 4, in making out the contour of eruptive blotches much better than with the unaided eye.

There are sources of error of which account must be taken. If the subject presents spots of redness upon the face there are some which are invisible to the unaided eye, and which become visible when one employs the colored glass. We must have a care not to be deceived by the marbled condition which the skin at times presents. Likewise dirty spots may be mistaken for eruptive elements, since by the blue glass, just as by photography, all sense of color is lost. There is thus a real education of the eye necessary to avoid falling into these errors. In taking into account all these observations, the author has been enabled to affirm the eruptions of eczema at least twelve hours before they have been visible to the naked eye; he has also been enabled to perceive eruptions of measles in situations where they were not apparent to others.

**Treatment of Symmetrical Generalized Diffuse Scleroderma.**—Dr. Moreau has treated in the last three years five cases of symmetric diffuse scleroderma by a special medication which has given him two complete cures and three instances of decided and lasting amelioration. The method consists in giving hot baths of three to four hours' duration, containing a strong decoction of valerian root, and of giving daily massage with a pomade containing twenty grams of extract of valerian, six drops of essence of valerian, in forty grams of vaseline. The use of these must continue several months in order to obtain a result. The observations published by the author seem to be quite thorough, but we must not forget that there have been obtained equally good results in scleroderma from massage carried out with simple lard, or better still, with cod-liver oil.

**The Period of Decline in Blennorrhagia in Men.**—Dr. Eraud, of Lyons, has just caused to appear in *La Semaine Médicale* an excellent resumé of what is actually known on this point. This period of decline of gonorrhœa is by far the most important period, for bacteriological researches now show us that it may be a danger for a very long time for those with whom the contaminated subject may cohabit. The last stage of blennorrhagic urethritis is that in which there is presented in greater or lesser quantity in the canal an albuminoid substance which at times communicates a viscous and glue-like consistence to the discharge and to the linen soiled by it. It is from this substance that the little masses and filaments observed in the first jets of urine are formed in an individual who has been affected with gonorrhœa. We can distinguish three species of these masses and filaments: 1, the urethral; 2, the prostatic; 3, the vesical. 1. The urethral filaments are by far the most important. Independently of the mucine which constitutes the substratum of these productions, we find leucocytes, epithelial cells and parasites. In acute blennorrhagia the filament is thick, white, and is broken up by the needle into thread-like bundles which are glairy or gelatinous. It is generally elongated, swollen or cylindrical. It is constituted almost in its totality by leucocytes and young purulent globules. Gonococci are found, either scattered or in little intraglobular collections, but are less numerous than in the discharge. The filament of the subacute or chronic stage are shorter, not so thick, not so white as those of the acute period. They are constituted by mucine (which is now quite abundant), by a few

scattered epithelial cells, but especially by large purulent globules having multiple nuclei more or less deformed. Between the nuclei, in their interior or upon their borders, are found quite frequently groups of gonococci in two, three or often more, together. The author insists on the fact that the search for gonococci in these filaments is often most difficult, that very often they are not discovered until after numerous fruitless examinations. The rather deep studies which he has made of the subject lead him to think that the gonococcus is found in many more instances than is at first supposed, and that it is to be found long after the onset of the affection. Indeed, he has been able to find it again two, four, six, eight, nine, twelve, fifteen and even twenty-five years after the original gonorrhœa.

The presence of leucocytes in these filaments is, according to the author, the index either of the present existence or of the future unforeseen occurrence of the gonococcus. 2. To obtain prostatic filaments it is necessary, after the patient has been caused to urinate, to palpate the prostate by rectal touch and to press upon the gland. The patient is then told to make the attempt to urinate again, and he passes about twenty-five or thirty grains, perhaps, of a fluid having a more or less suspicious aspect, in which float short masses more or less opaque, which are readily broken up and are composed of granules, mucoid masses and epithelial débris. These are the intraglandular products of the parenchyma, which carry along with them parasites of the coccus genus, at times bacilli, and occasionally yeast plant forms. But in some cases we can also find in the fluid real *filaments*, which are constructed by mucus, pus corpuscles more or less young, and by a few epithelial cells. We can then find the gonococcus. It is probable that they come from the ejaculatory ducts. The author believes that *true* prostatitis is caused by a parasite other than the gonococcus. 3. Vesical masses can be best studied in women. These are little collections of grayish-white aspect rather than whitish, offering a certain analogy with fine grains of semoule. They are composed of epithelial cells without pus globules and do not inclose any mucine. They come simply from exfoliation of the vesical epithelium and do not contain any parasites. The author concludes from a large number of observations carefully conducted by him that in a healthy subject who has never had any affection of the urinary passages, and especially no urethritis, that no abnormal secretion is found. As soon as filaments are found in a patient we can affirm that he is not cured, for he carries with him the germs of his disease. Blennorrhagia thus appears in a new light. Like syphilis, it may have its phases of activity alternating with phases of repose. These recrudescences after excess in drink, fatigues, or coitus at times without appreciable cause. These are not blennorrhagias of new development, as has been long pretended, but recurrences of an old malady. In these cases the gonococcus, which was invisible, or, to speak more correctly, in a latent state in the urethra, reappears and multiplies anew, although ordinarily it is less abundant than in the pus of an initial blennorrhagia. Besides the other characters of these discharges of recurrence are the absence of incubation, the slight amount of reaction or pain, the rapid improvement and even rapid cessation of the symptoms. In point of view of the contagion, old blennorrhagias can be divided into two categories: the first comprises those who have from time to time light recrudescences, which are characterized by the white appearance of the secretion or occasionally yellow which they present. These patients are not at all surprised

to learn that their discharge is contagious. The second category includes those patients who, seeing no longer any drop at the meatus, or only noticing it as an intermittent occurrence, are quite satisfied with their condition and believe themselves cured; and still these persons may transmit the disease by the little flakes, or by the threads which, at the moment of ejaculation, are carried along and surrounded by the spermatic fluid and carried into the uterus, or which are once more deposited at the orifice of the urethra, an old blennorrhagic can then, at a time when he has all the appearances of complete cure, be a danger to the virgin woman with whom he marries. These are considerations of a capital importance and which call for most careful examinations before giving to such subjects permission to wed, the more since we do not yet know exactly what may be the ulterior consequences of blennorrhagia upon the functions of the genital organs.

**Parablennorrhagic Cystitis, or Prolonged Blennorrhagic Cystitis.**—Dr. Bazy has studied in a recent article the late consequences of blennorrhagia. There are cystites which have begun with a symptomatology more or less acute in the course of a blennorrhagia, which are afterward quieted for a longer or shorter interval, have appeared cured, and have then revived from time to time. Now, in these cases, gonococci are no longer found, but staphylococci or the colon bacillus. The gonococcus has played the rôle of provoking agent. It has disintegrated the epithelial covering and has delivered it over, disarmed, to the action of other saprophytic microbes of the canal, the only ones that we find ordinarily in these cases of cystitis remote from the initial blennorrhagia. It is for this motive that the name parablennorrhagic is more appropriate for them than that of blennorrhagic, to indicate that if they have their origin at first in a preceding blennorrhagia they are not kept up by the characteristic infectious agent of blennorrhagia.

The author has been able to observe such cases one, two, three, and even up to twenty or thirty years after the first blennorrhagia. In some patients there is no interruption between the initial blennorrhagia and these accidents, however long may be the interval which separates them. They have, in point of fact, always felt their bladder; the slightest departure from their régime has been followed by a painful reminder in this region, and has been followed by suffering or, rather, by a burning during the act of urination. In others, on the contrary, the pain has been so fleeting, so light, that it has scarcely attracted their attention, and we have to insist upon the point and cause them to reflect for a time before they remember that such has been the case. In others, finally, there is an absolute void between the long past blennorrhagia and the present cystitis, and it is only by analogy with the preceding factors that one can make this category of cases enter into the same class. It is even, up to a certain point, questionable whether it should be done, since we cannot claim that an individual is refractory to the other causes of infection and to the other causes of cystitis by reason of the fact that he has had blennorrhagia.

**Study Upon Mercurial Frictions.**—Dr. Cathelineau has just undertaken, in the service of Professor Fournier, at the St. Louis Hospital, a whole series of experimental researches, to enable him to determine the manner in which mercurial frictions act upon the organism. It is well known that several hypotheses have been advanced on the subject. According to some the



mercury penetrates directly through the skin in a state of extreme subdivision. This theory has been vigorously assailed in recent times. For others the mercury penetrates the organism under the form of soluble absorbable compounds produced by the chemical action of the fatty bodies of the ointment base or the products of secretion of the skin. For others it penetrates under the form of mercurial vapors formed in the hair follicles and sebaceous gland follicles which the inunctions have filled with mercury. For others, finally, the mercury penetrates in the state of vapor by pulmonary inhalation, and this is indeed the best demonstrated fact up to the present time. Every individual subjected to the process lives, perforce, in an atmosphere where the mercury of the ointment continually emits vapors which are given off to the surrounding air, and decisive experiments have shown that it suffices to place an individual in a medium saturated with mercurial vapors in order to find mercury in his secretions, and in order to have it act upon syphilitic manifestations. Studying the emitting power of the various mercurial preparations from the standpoint of mercurial vapors, the author has become convinced that the pommades made with lanoline, vaseline and lard have a vaporizing power much inferior to that of mercurial chalk or of mercurial flannels. Knowing this power of vaporization for Neapolitan ointment, the author has sought the quantity of mercury contained in the urine of patients subjected to inunction. It must be admitted that all the mercury volatilized has not been absorbed by the patient, since we find some in the urine of those about the patient. Furthermore, a portion of the volatilized mercury becomes fixed in the organism; it is eliminated, besides, by the saliva and the bowels. It results that we should find in the urine of patients a quantity of mercury much inferior to the quantity volatilized. Now, it is the opposite of this that the chemical researches demonstrate. The urine of twenty-four hours contains always a quantity of mercury larger than that which ten grams of ointment used in friction would emit in the same period of time. Now only four grams of ointment were employed in the inunctions made. These researches demonstrate, therefore, in the most irrefutable manner that when we employ mercurial inunction the mercury does not penetrate alone by the way of the lungs into the economy.

**Auxiliary Treatment of Syphilis.**—In one of his recent lectures Dr. Mauriac insisted upon a most important point in practice, and, unfortunately, one too often neglected—the necessity to treat the various morbid states of a general nature which syphilitics present. When they are distinctly scrofulous mercury is not injurious. It is quite as efficacious as in those who have a good constitution. It does not aggravate the scrofulous condition, but it does not attack it either. In these subjects the treatment par excellence is that by the iodide of potassium, for it often modifies the strumous constitution at the same time that it acts against the syphilis. It is often well to prescribe cod-liver oil in large doses in the syphilitic adenopathies in strumous subjects, in gummata of mixed nature, which pertain as much to the scrofula as to the syphilis. The tincture of iodine is also, in these cases, an excellent preparation.

L. BROCC.



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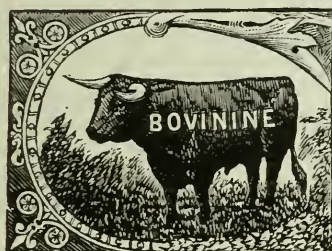
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